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The Student and Neurosis

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Podiumsdiskussion

J.-E. MEYER, Göttingen

Teilnehmer

V. J. BIELIAUSKAS, Cincinnati, O.; C. BLOCH, Brüssel; F. CLARAMUNT, Madrid; P. FAHY, Dublin; CHR. LUCAS, London; C. P. MCAREE, Burlington, Vt.; E. SPERLING, Göttingen; H. U. ZIOLKO, Berlin

Es wurde zunächst von jedem Gesprächsteilnehmer eine kurze Einführung in die speziellen Arbeitsgebiete gegeben, die sich aus der unterschiedlichen Struktur der Hochschulen in den verschiedenen Ländern und der Beratungseinrichtungen ergeben. BLOCH beschreibt den Aufbau des «Service d'Aide Psychologique aux Etudiants de l'Université Libre de Bruxelles», der aus 3 Psychiatern, 2 Psychologen, alle psychoanalytisch ausgebildet, sowie einem Sozialarbeiter besteht, die allerdings nicht hauptamtlich dort beschäftigt sind.

FAHY betont, dass ein grosser Teil der Probleme der Studenten ausser durch ärztliches Eingreifen auch durch Betreuung und Beratung angegangen werden können, weshalb ein «Counsellors Club» besteht, dem Geistliche, «Deans» und Mitglieder der Universitätsverwaltung angehören. Neben der Betreuung der immer zahlreicher werdenden Rat suchenden Studenten, bei denen die «subpathologischen» Zustände überwiegen, gehört die Unterweisung des Lehrkörpers im Erkennen und Umgang mit erkrankten Studenten zu den Aufgaben der Stelle.

Über die Finanzierungsprobleme äussert sich besonders CLARAMUNT aus spanischer Sicht. Dort würden die Studenten über die studentische Krankenversicherung in privaten Kliniken behandelt. Da nur die schweren Fälle diese Behandlung bekämen, sei die Erfassung der Häufigkeitsverteilung äusserst schwierig.

MCAREE betont, dass etwa 10% der Studierenden in den USA an schweren emotionalen Konflikten leiden und deshalb Hilfe suchen. Hinzu komme das Problem der anwachsenden Suizidrate sowie der Gebrauch von «psychedelic drugs». Wegen der Anpassungsprobleme der sich stän-

dig verändernden Umwelt habe sich der Hochschulpsychiater etwa in der Hälfte seiner Zeit mit den Hochschullehrern, der Administration und den studentischen Führern zu beschäftigen. SPERLING stellt die Frage nach der Möglichkeit des Erreichens von Problemstudenten und betont, dass von den tödlich ausgegangenen Selbstmordversuchen unter den Studenten keiner eine psychiatrische Poliklinik oder die studentische Beratungsstelle aufgesucht hatte.

Die Suizidproblematik wurde als erster Diskussionspunkt aufgegriffen, wobei die überwiegende Meinung der Teilnehmer war, dass der studentische Selbstmord doch kein häufiges Phänomen sei. FAHY bezieht dies auf die religiöse Einbettung der Studentenschaft. Auch BIELIAUSKAS, der an einer katholischen Hochschule tätig ist, verneinte Suizidprobleme.

Bezüglich der Symptome, derentwegen Studenten einen Beratungsdienst aufsuchen, fand ZIOLKO in etwa 90% Lern-, Arbeits- und Leistungsstörungen. Diese seien Teil eines Syndroms, zu dem auch die Angst vor dem Leistungsbeweis – etwa im Sinne der neurotischen Prüfungsangst – gehöre. Immer fänden sich Beeinträchtigungen der sexuellen Fähigkeiten im Gesamtsyndrom. Die Zahl der Psychosen sei erhöht. FAHY unterstreicht die Angstreaktionen der Patienten aus dem ersten Studienjahr, die einen Zusammenhang mit Anpassungsschwierigkeiten an die Universität erkennen liessen. Andererseits werde, wie LUCAS berichtete, eine sehr unterschiedliche Symptomatologie beobachtet, die vorübergehende leichte Störungen, aber auch schwere akute Krisen beträfe. Er betont die Schwierigkeiten der Auswahl der Fälle für eine Kurztherapie und weist darauf hin, dass langdauernde Psychotherapie ausserhalb der Universität erfolge. Zu dieser Frage äussert SPERLING, dass die studentischen Patienten, die sich nach Vorstellung in der Beratungsstelle doch nicht einer Behandlung unterziehen, besondere Bedeutung hätten: Es handle sich erstens um Patienten mit Verwahrlosungszügen, die nur im Auftrage von anderen kämen, zweitens, ihnen verwandt, um Alkoholiker sowie drittens um Phobiker, die sowohl Einzel- als auch Gruppenbehandlung nach kurzer Zeit abbrächen.

BLOCH hält es für besonders notwendig, der Struktur der Universität und der Organisation des Studienganges bezüglich der Auslösung neurotischer Dekompensationen bei den Studenten Beachtung zu schenken. Er betont, dass die Patienten mit neurotischen Störungen wohl Neurosen durchgemacht hätten, aber dass auch verschiedene Elemente des Universitätslebens besonders schwierig zu bewältigen seien, wobei die spezielle Stress-Situation der Examina in Belgien eine Rolle spiele.

Die besonderen Identitätsprobleme bei Collegestudenten betrachtet BIELIAUSKAS von 5 Gesichtspunkten: Dem Erlernen der sozialen Rolle, der sexuellen Identifikation, der Entwicklung von Interessen und Hobbies, der Religion sowie der Identifikation mit dem erwählten Beruf. In allen Bereichen stellen sich Konfliktquellen. Ausserdem spiegele sich die allgemeine gesellschaftliche Verwirrung bei den Studenten wider. Auch CLARAMUNT betrachtet aus spanischer Sicht die Probleme der Umstrukturierung der gesellschaftlichen Wertorientierungen und betont für die psychotherapeutische Behandlung den existentiellen Zugang wegen der in seinem Lande bevorzugten humanistischen Tradition. ZIOLKO zentriert seine Betrachtungen auf Triebkonflikte, und auch LUCAS meint, dass die dispositionellen Faktoren ausschlaggebender seien als Konflikte, die aus der Umwelt stammen. Da jedoch die persönliche und familiäre Umwelt vom Universitätspsychiater schwer zu beurteilen sei, habe er die Aufgabe, auf die soziologische Erforschung der Interaktionen von Student und Fakultät hinzuwirken. Hier dürften sich wesentliche Therapieansätze für die Zukunft ergeben. Auch SPERLING weist auf die Bedeutung eines studentischen «social work» hin, besonders um depressive Patienten überhaupt in Behandlung zu bekommen. Ebenso legt FAHY sein Hauptgewicht auf das sogenannte «case finding», weshalb der Psychiater als Allgemeinpraktiker arbeiten sollte. MCAREE spricht sich für eine Einbeziehung halbausgebildeter Hilfskräfte aus anderen Fakultäten in den psychiatrischen Beratungsdienst aus, um einen möglichst weiten Einwirkungsradius zu erreichen.

FAHY warnt vor kritikloser medikamentöser Behandlung von Studenten in Konfliktsituationen, weil in diesem Alter eine Suchtgefahr bestünde und es sich häufig um Entwicklungsprobleme handle, die ohnehin nur vorübergehend seien.

Abschliessend wurde von MEYER auf die Vielschichtigkeit der Aufgaben dieses neuen hochschulpsychiatrischen Dienstes und Wissenschaftszweiges hingewiesen. Zu der Beratung für die eigentliche Studienbewältigung kommt die Behandlung manifester neurotischer Störungen und eine Mittler-Stelle zwischen Studenten und Lehrkörper bzw. Administration.

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Problems of Psychotherapy with Students

P. FAHY, Dublin

It is with trepidation that I address such an experienced gathering on this subject. My experience in dealing with large numbers of students in psychotherapy is brief but during the three years of my experience in this field I had the opportunity of spending over twelve months, during which time I dealt with all referrals to the Student Health Service at our College. There are almost 9,000 students at University College, Dublin. The psychiatric service was established about three years ago as an emergency service, but demand necessitated the establishment of a regular clinic. The physician who ran the medical service died early in the term of the Academic Year 1966/67 and I undertook to conduct all aspects of the Student Health Service. Therefore, for over a full Academic Year all students presenting at the University College, Dublin, Student Health Service have been seen initially by a trained psychiatrist. Indeed all students continuing under medical supervision during that time were also under my care. The majority of students who might require in-patient psychiatric treatment came under my care. A number of students were seen by me during unofficial hours, in my private practice, and I provided an emergency domiciliary service. Thus I hoped to see as much of the range of problems as possible.

My official title is Student Adviser and students may approach directly or be referred by a staff member. The service is informal and totally confidential; the College authorities have no claim to notes and no reports are issued without the student's consent.

In the Academic Year 1966/67 at least 2,300 appointments were filled to the Student Health Service. 1,500 of these appointments were psychiatric, with 250 new cases seen that year. These are round figures.

The psychiatrist undertakes diagnosis and treatment on an out-patient basis. The College has not yet acquired the facilities for in-patient treatment but the matter is in hand. Since coming to work at the Student Health Service one feels that a great deal of experience has been acquired as it was necessary to establish a service *de novo*. The volume of patients continues to increase and there is an unavoidable accumulation as one takes people on for long-term therapy.

As the majority of cases are between 18 and 21, one is dealing with a population at a stage in life where emotional problems appear to be part of the normal learning and maturing process. While it is important to detect 'illness' at the earliest possible point, there is a danger of creating psychiatric invalids through inappropriate handling. The student may be working through the so-called 'identity crisis' and learning to cope with anxiety and depression.

The immediate problem at first interview is one of assessment. I find the orthodox psychiatric label of little value in this matter and tend to classify people arbitrarily according to the degree of disruption of function (that is, academic or social) caused by the condition. At the 'normal' end of the diagnostic spectrum would be problems with symptoms of stress, which would not be of consequence in less demanding circumstances. Even a mild bout of insomnia may cause an examination failure. Usually there is a background of domestic upset; in 75 % of cases in a small survey, the patients described varying degrees of difficulties in communication between themselves and their parents. One felt that had there been good family relationships the family might have been able to tide the patient over the crisis. At this point a counselling service at least is of great help.

Normally it would be desirable to embark on a full investigation, but time-limits, inherent in University life, create a special problem. The examinations are often a matter of weeks away, the term is short, even the length of courses is such that the student is not available for a planned course of therapy. Immediate relief is usually mandatory. Too rapid progress with searching psychotherapy may cause more disturbance. There may not be permission to involve the family. A great deal will therefore depend on the doctor-patient relationship.

One does not wish to introduce young people to the drug habit, but chemotherapy appears to be essential for rapid results. One hopes to tide people over the crisis and to embark on more fundamental therapy later.

Most patients tend to present when they feel *in extremis,* although the number presenting with 'sub-pathological' conditions is increasing. Short-term bed rest with modified narcosis techniques is useful to attain a state where the student is receptive to psychotherapy. I feel one must be prepared to be flexible and use the full range of the psychiatric armamentarium to implement relief speedily.

With regard to the style of psychotherapy, one must choose between helping a small number at depth, or as a compromise, attempting to aid as many as one can while risking superficiality.

The first interview is crucial. Sceptical clients may not return. I find it is necessary to be more directive with people in this age group than with more mature people. It is necessary to establish rapport quickly and to give the student an outline of proposed action. Again, better results are achieved if the patient is seen within a week for the second interview, for which interval of time it is necessary to give detailed instructions regarding daily living, if the established neurotic life style is not to negative therapeutic effort. Indeed the emerging neurotic life-style seems to be sufficient justification in itself for providing a counselling service to these young adults, potential parents. One has a unique opportunity for prophylaxis in a social sense here.

In our social setting, psychiatry is still gaining acceptance. Prejudice and indeed opposition does not seem to be confined to any particular stratum of the population, and parents will naturally resent an outsider's interference with their progeny. It is often difficult to persuade the student to inform the parents of the problem, and even following this, it is difficult to manipulate the environment or home situation from a distance. The goodwill of the academic staff can only be acquired through direct personal contact with the therapist and I have found in my University that the academic people are most helpful, particularly when one has established contact with them and reassured them of the fact that the Health Service would not be a party to manipulations by the student, in disciplinary and administrative problems.

Summary

So far I have found that the greatest problem in conducting psychotherapy with students is that posed by the time limits inherent in the University curriculum and by examination deadlines. It is difficult to comment at

all, upon the problem of assessing the extent to which the actual structure of the curriculum precipitates illness, and to what extent one ought to interfere, if at all, with the people who are 'finding their feet' through trial and error, in this transitional period of life.

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The Ecology of Colleges and Universities and the Psychotherapy of Students

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Despite the fact that attention has been drawn to the social function of psychiatrists who are consultants to university health services there has been a relative neglect on the part of psychiatrists of this particular function. In the United States the Group for Advancement of Psychiatry has in two papers drawn attention to the importance of the psychiatrist, not only in terms of individual consultation but in terms of availability for consultation to members of the administration and faculty of the college. This is seen as an attempt to grapple with the actual climate for mental health within the institutional setting which, by its very nature, as an authoritarian disciplinarian structure might be supposed to set up influences that are pathogenic as far as mental health is concerned.

To complement and in a sense compound this particular issue there has been little or no demand on the part of the administration of colleges and universities and indeed on the part of the faculty for this type of consultation and much of the planning that one sees. As far as the psychiatric division of student mental health services goes, its concern is with the old model of individual psychotherapy and individual consultation. Much lip-service is paid to the principle of administrative and faculty consultation but in practice this occupies a very small proportion of the psychiatrist's total time. It is my purpose in this paper to give examples of situations in which the administration has acted without apparent reference to psychiatrists or experts in behavioural science and adolescent psychology and where this has resulted in mass disciplinary problems, near riots, and in some cases, distinct challenges to the administrative structure of the university. All of these at the moment are being viewed

as products of a certain emotional climate, both individual and group, therefore understandable, therefore capable of manipulation, therefore, preventable.

When one considers the reasons for the psychiatrist's failure to define his social role within the college community, several factors spring to mind. In the first place, the psychiatrist by virtue of his training, and I refer particularly to the current mode of training within the United States, is geared toward an individual model. Individual psychotherapy still remains high in our value system. We are uncomfortable in any other role and indeed many of our colleagues feel psychiatrists should not venture beyond the therapeutic role. This, I feel, is an inflexible attitude and one which denies the fact that we are dealing with a profession in rapid transition where we shall be increasingly called upon to play the role of informed commentator in the problems that beset all of Western civilization: the problems of discrimination and racial prejudice, the problem of crimes within our cities, the problems of the ruthlessness and apathy of our younger generations. It is, one feels, an abrogation of responsibility on the part of the psychiatrist if he does not concern himself with these matters.

In the second place, of course, we must admit that it is not entirely the psychiatrist's fault for a great deal of administrative and faculty resistance is concerned in this entire question. Psychiatrists are not only respected, in some instances they are actually feared and whilst much of this is irrational it should be pointed out that to some extent we have facilitated such a point of view, inasmuch as cleaving to a solidly reductionist line for many years has led to certain expectations on the part of administrators and faculty dealing with specific behavioural problems. The administration is concerned that the psychiatrist reduces all problems to sex and aggression. We are skilled at theoretical formulations but when it comes to practical suggestions as to how to deal with the situation it must be admitted that we do not create a public image of being the most practical profession in the world.

When we turn to the actual need for a psychiatrist to broaden his role and more clearly define it as a social one as well as a therapeutic one, we should have some regard for the unique position of a college psychiatrist. By and large he has closer and more sustained contact with students than practically anybody else on campus. Therefore, he is in the unique position, not only by virtue of being 'with it', as the students would say, but by virtue of his special interest in adolescence he can also present

informed opinion. The work of Erik Erikson [1950, 1959] is familiar to all of us and has given us unique leverage on the problems of adolescent and early adult life. Indeed it is the currency of practically all college psychiatrists, and, yet, one wonders how much this thinking has permeated into administrative and faculty thinking. Certainly when one examines some of the situations which I shall later make reference to it is rather clear that there has been a relative loss of clear-sightedness with the fact that we are dealing with a rather different psychology with younger people and that they are grappling with rather different problems than the problems of adults or 'mature people'. Of course, it is also true that the concepts of Erikson require a great deal of expansion and they need to be adapted more specifically to an understanding of group social process. They provide partial explanation of the youth movements which are sweeping the world but more in terms of theoretical formulation is required. In essence, a complementary set of concepts are required to the work of Erikson.

It is almost superfluous to say that a youth culture has been established throughout the world since the beginning of the 20th century. Not only does youth play a prominent role throughout our colleges and universities but in many countries they have become an important force in the political future of the nation. This is a relatively new phenomenon in the United States where, despite the overall accent on youth, the command generation still consists largely of people of early middle age and it is only within recent years that a relatively young president was elected. Now, however, America, too, has begun to feel the impetus of its youth in a very direct fashion. Not merely are we dealing with youth as a force influencing ladies' fashions or popular songs but the voice of youth is very directly to be heard in protests against the Vietnamese war and these were largely inspired by college students in their initial stages. Many of the militant civil rights groups are led by youth. All of this, of course, is part of a world-wide trend, for university and college students have been an active force to be reckoned with in many countries throughout the world since the beginning of the century. For example, youth played a very direct part in the formation of the government of modern Turkey. Students as an active political force have long been recognized in South America, for example, in Argentina and Bolivia. In the Far East student unrest was directly responsible for the fall of the government of Syngman Rhee and is also held accountable for President Eisenhower's cancellation of his trip to Japan during his second term. In view of all this it is quite

clear that students and youth are playing an increasingly important role in our society and in shaping and influencing even the executive aspects of our society. Inevitably, with the increasing demands for college admissions, this vital segment of our society will broaden and expand its influence so that it behooves us to know a great deal more about its psychological attributes, its value systems, and its mores before we can even begin to presume to influence it.

One could make a rough subdivision of youth group movements into a) essentially political: for example, the new left, the young conservatives, the anti-Viet Nam and civil rights groups; b) essentially social, philosophical, and recreational: for example, the various offshoots of the psychedelic movement, free love groups, so-called hippies, the folk singers, etc. These are groups with no very clearly articulated political purpose but sharing a common philosophy of life or common ideas as to how to achieve that philosophy of life; c) essentially deviant and anti-social groups: these include many of the youth gangs and also to some extent a fair number of supposedly political groups. In the mind of the relatively uninformed public the shades of differentiations between these groups blur somewhat and, of course, it is true that there is a transition from one group to the other. However, it is also clear that even college administrators fail to make clear-cut distinctions. Legitimate protest or political activity is misinterpreted at best as an offshoot of hippie philosophy, at worst as anti-social deviance.

If we seek for common denominators in all of these youth movements, we find that these disparate types of behaviour seem to emerge from the same common matrix. FISHMAN and SOLOMON [1964] have dealt with this particular issue in considerable length in an attempt to give social perspective to Eriksonian concepts. Amongst other things they cite identity issues, idealism, responsiveness to social change and discontent, strivings for adulthood and autonomy, the need for expressive behaviour and public recognition, the need to take risks and prove oneself and to accept the consequences of one's actions, fidelity, morality, purity, and sacrifice.

Much of FISHMAN and SOLOMON's [1964] attempts at conceptualization of psychological common denominators of youth movements and groups are clear-cut extrapolation from already well-known ideas concerning the nature of adolescence and youth, for example, the question of identity, the question of relative impulsivity, the question of striving towards adulthood and autonomy. However, there are certain new dimensions

introduced. Responsiveness to social change and discontent is to some extent applicable more to the generation of the 60's for this type of social concern and engagement was relatively uncommon in the late 50's. In fact, as far as the generation of college students of the 50's goes, they will probably be best remembered as the 'blah' generation.

When we consider some of the other points such as fidelity, morality, purity, and sacrifice, we can perhaps summarize this under the central concept of morality or an absolute ethic, for contrary to much of the popular press conceptualization of young people, youth seems to suffer not from too little conscience but rather from an excessive conscience and this produces a tendency towards absolutes. Even such seeming immoral groups as the free love groups set about this with what to adults must seem dreadful seriousness. Seymour Lipset [1965] in his analysis of the Berkeley student revolt has made reference to this question, and quotes Max Weber who also recognized this tendency of youth towards 'a pure ethic of absolute ends' while mature men tend to espouse 'an ethic of responsibility'. To quote Lipset [1965], 'The advocate of the first fears that any compromise in matters of principle will endanger the 'salvation of the soul'; the proponent of the second fears that an unwillingness to confront the complex 'realities of life' may result in the 'goals being damaged and discredited for generations because responsibility for consequences is lacking'.

In other words, the tendency of youth is to deal in absolutes and of adults to deal in compromises. It is natural then that youth is attracted to extremes of oversimplification in all things and to excessive behaviour in large measure. This may be expressed in direct attraction to causes but more often than not the attraction is as much to the charismatic leader of the cause or espouser of the cause who forms a direct identificatory model for members of the youth movement. Parenthetically, it may be added that oftentimes the charismatic leader may readily belong to an older age group but clearly retains many of the attributes of youth and adolescence in his absolute attitudes and relative ruthlessness.

All of this tends toward an intolerance of what seems to adolescents an adult hypocrisy and ambiguity. Perhaps ironically one of the tasks of youth is to learn to tolerate this and to develop the so-called 'ethical responsibility'. It could also be said with some measure of truth that youth is determined to attain resolution of this task and, as Erikson [1950] has often pointed out, to place themselves in an historical perspective with regard to the value systems of their parents. There is not by any

manner of means a total rejection of parental values as has been shown by LIFTON [1964] in his excellent papers on Japanese youth.

Amongst the many examples [LIPSET, 1965; ABRAMS, 1965] of situations in which the generation gap has become tragically apparent were the incredible events that took place on the campus of the University of California at Berkeley and indeed even now have not been fully resolved. To give perspective on this I must give a brief historical account. Of neccessity this contains certain biases as I have to rely on accounts given of this situation and unquestionably much will yet be written about it which may shed further light on the problems and the situation itself is infinitely complex. However, despite this, certain facts emerge. From September 1964, to January 1965 the campus at Berkeley was the seat of student unrest almost to an unprecedented degree on United States campuses. This situation had its origin in an act on the part of the university administration placing a small strip of land which the student off-campus political action groups had used for the purpose of solicitation of funds, enrollment of members, etc., within the property of the university and therefore subject to university regulation. This outlawed the political activity that had been conducted in this setting. The students organized the Free Speech Movement to combat this situation and to call for a revision of the university's view on political action throughout the campus. This resulted in a virtual civil war within the university.

Student sit-ins, protest demonstrations, strikes were rampant. Many arrests took place. The overall integrity of the university was threatened.

There are no heroes or villains readily emergent from this total situation. However, it must be said that two personalities dominate the scene, those of Clark Kerr, the President of the University, and Mario Savio, the leader of the Free Speech Movement. We can ask many questions about the situation. For example, what led to the evangelical zeal with which the students pursued this cause? Why could it not have been settled more readily and quickly? Did, in fact, the university administration act in such a manner as to worsen the situation?

There has been much written from the standpoint of educators, undergraduates, and faculty members on this whole issue. Relatively little has been written by psychiatrists and psychologists and many of the sociologic writings deal with events that antedate the actual period under question.

If one examines the chronology of events it is quite clear that at one point, October 2nd, in response to particularly severe prolonged demonstration during which the students surrounded a police-car in front of the

university, bearing away one of the student demonstrators, the university, under the leadership of President Kerr and Chancellor Strong, met with student leaders and demonstration spokesmen. They drew up an agreement which was conciliatory toward the leaders of the demonstrations and which set up a committee to look into the whole question of political action on campus. At this time the students accepted the situation almost with relief it seems. As part of the bargain they had agreed to desist from all forms of illegal protest against university regulations. However, bit by bit over the next few weeks in response to claims of breaches of the agreement on the part of the students the administration withdrew from the terms of this agreement. This ambiguous attitude of the administration and their vacillation in the face of the students served to reinforce their feelings that whilst the university *seemed* to act toward a greater liberalism, underneath they were rigid and unwilling to listen to what the students considered a just cause. Claims that the students were communist-inspired also served to anger the Free Speech Movement leaders and all of this culminated in a violent resumption of the demonstration until a particularly massive demonstration on December 2nd. The university then slowly retraced its steps and acceeded in fair measure to the demands of the demonstrators. In retrospect, the administration's three greatest failures were their inability to recognize this absolute spirit that existed within this large group of students: the ambiguity and vacillation of their particular attitude, and what appears to be a lack of continuing dialogue to allow some modification of the students' absolutism, for whilst young people would seem to demand unconditional surrender, more often than not they are not really expecting a full realization of their demands, save in fantasy and they are indeed somewhat frightened of the power that they possess.

Apart from these specific considerations on student absolutism and its hardening in the face of suspected adult hypocrisy, there is also another very vital question to be learned from the Berkeley revolt. At Berkeley there are close to 30,000 students. This is a world-wide trend in universities. Lipset [1965] quotes, 'At Mexico City there are over 65,000 students, Buenos Aires 70,000, at Calcutta more than 100,000, at Rome about 50,000, at the University of Paris 70,000, at Moscow over 30,000. We are dealing with the problems of the multi-versity as Clark Kerr (1965) so aptly phrases it. It is in some sense ironic that Kerr has an overview of the situation facing the student in such a setting, his identity problems and anomie, his loss of links with the faculty, and his tendency

to look upon himself as a member of a class or, as Kerr puts it, "A Lumpen-Proletariat".'

It may also be added that LIPSET [1965] considers 'the high incidence of intense student political activity is in some sense an indication of the failure of the university as an academic community, particularly since in most cases such activity involves a rejection of the intellectual leadership of the faculty, a denigration of scholarship to a more lowly status than that of politics within the university itself'.

It might be argued, however, that the ambiguous attitudes of the administration reflect in some sense the compromise of the mature man and the middle way. However, I do not think of this as a valid argument for we are not dealing here with policy based on the resolution of an ambivalent attitude but more with the sort of a double bind strategy involving wide excursions from one extreme of position to another.

This is not necessarily in relation to underlying conservative attitudes as borne out by a recent personal experience in consultation with a small liberal arts college in New England where the administration was having extreme difficulties in connection with the use of psychedelic drugs and they felt that a psychiatrist might be able to identify some of the difficulties. One striking feature in the situation was the fact that whilst the overt stated policy, although rather feebly stated, was in the direction of censure of such activities. However, during my meetings with faculty it became abundantly clear that many of the younger faculty, who in this case were also integrally involved with the administration by virtue of the organization of the college, seemed openly sympathetic with the students and seemed to some extent to be coping with their own as yet unresolved adolescent conflicts. In what I feel was a profitable meeting with the entire group of faculty and administration, I pointed out some of these things and attempted to correct the notion that free expression, experimentation, and acting out are always 'a good thing' but pointing to the real need for controls and unspoken demands for controls of adolescents and young adults. There was also, of course, the entire question that in encouraging this type of self expression it was also in fact self defeating towards the entire educational establishment itself and imperiled its very existence. Here again we are confronted with the same ambiguity, the same vascillation, and the same entrenchment of attitudes on the part of the students in the face of this.

The same is true in the face of the so-called sexual revolution. Inasmuch as whilst there would be few people in the administration who would not

accept the fact that a marked change had taken place in attitudes towards sexual expression throughout the United States, they in many instances nonetheless continue to pursue anachronistic policies with great rigidity.

Influencing all of these situations is the fact that whatever policy is articulated it must be one that makes sense to students and it must be backed up with argument and must admit of the possibility of dialogue with the students in connection with its application. For whilst the young may not agree with the old they can at times respect them and respect a point of view that is based not on authority and the trappings of institution but on reason and common sense.

It would seem in all of this that the psychiatrist has a role to play, a point of view to advance unique in that it sheeds light on the difficulties of youth itself and whilst it avoids the pathetic fallacy in its viewpoint it also avoids the apathetic one.

Summary

In the American residential college and university, the articulation of administrative policy has, to some extent, been in general in most colleges independent of psychological insights into the nature of late adolescence and early adult life and has not been flexible enough to accommodate for changing value systems within this group of young people. Pursuing anachronistic policies has resulted in a relative failure on the part of college administrators to deal effectivly with such special circumstances as 1. the psychedelic situation, particularly the use of LSD and other hallucinogenic agents, 2. the so-called sexual revolution on American campuses, and 3. various peace and anti-Viet Nam War movements. Oftentimes, the publicly stated policy of the university is at variance with privately held viewpoints and this presents a situation of ambiguity and confusion to the adolescent and the faculty and administration do not prove satisfactory identificatory models. Inconsistency and ambiguity in this context are viewed as being much more unhealthy than a stated policy which may tend in the direction of either liberalism or conservatism, which the administration has made sincere attempts to justify.

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Short-term Psychotherapy with College Students: Prevention and Cure

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Introduction

While colleges and universities from their very beginning have been training experts in the health professions, their interest in using these experts systematically on college campuses for the benefit of students is a fairly recent one. The training of mental health experts such as psychiatrists, psychologists, social workers, etc. represents a twentieth-century expansion of the university. The application of such training on university campuses is an even more recent development. It is only as recently as 1957 that Dana Farnsworth, Director of the Student Health Center at Harvard University in Cambridge, Massachusetts, could proudly proclaim that 'Colleges discover the need for mental health' [5]. Harvard University already had in 1957 a psychiatric section in their Student Health Center which provided an extensive service to the students, as did the other specialties of the healing professions. During the last decade, most universities in the USA have established some type of mental health services for students. Some of such services are provided through the departments of psychiatry of the medical schools, some through student health centers, others through university mental health clinics, but the majority through the departments of psychology or their subdivisions.

There are certain specific reasons why the profession of psychology is carrying the chief burden of mental health services at the largest number of colleges and universities. The main reason for this is the fact that most colleges, especially the small liberal arts colleges in the USA, have existing psychology departments, while they could not afford a depart-

ment of psychiatry without having a medical school in their structure. The departments of psychology are at first academic departments of the colleges rather than treatment units of the mentally or emotionally ill. By virtue of this image they render certain protection to their clients from the stigma attached to individuals receiving psychiatric help. In addition, the psychologists deal with various facets of problems of living, such as vocational choice, academic difficulties, reading problems, not to speak about personal and emotional problems. There is no doubt that receiving help from a psychologist on a college campus is less threatening than seeing a psychiatrist in a medical setting at the college or outside. In addition, psychologists, especially those in academic settings, traditionally have been concerned with mental hygiene or preventive mental health and, by virtue of their concern, they have been quite sensitive to college students with problems.

There is no doubt that 'the principles and practices of mental health are no different in institutions of higher learning than in other communities' [5]. Consequently, there is no doubt that the college community requires no less attention from a medically trained psychiatrist than their counterparts outside the college [12]. However, in most instances regular psychiatric services are not available due to manpower shortage and many colleges cannot afford such services. Even there, where psychiatric services are provided through medical school, they do not seem to be satisfactory, because they fail to recognize problems unique to college students. FARNSWORTH [5] and WITTINGTON [12] stress the lack of specially trained psychiatrists who would deal with the college population. Both of these authors describe settings dealing with students' mental health existing outside of medical school settings, even in instances where the university includes a school of medicine in its structure.

The mental health problems which college students experience are quite similar to the problems their non-collegiate peers experience, with the exception that the college community represents a concentration of above-average people who are more intelligent and probably more sensitive than others of their age group. It is quite understandable that intelligent people experience stronger doubts about their abilities because they have a higher degree of insight and higher sensitivity to failure than average or below-average people. Obviously, college students are living in a highly competitive environment and they are prone to experience more challenge, more anxiety and more guilt. The career of a college student is directed toward accumulating knowledge, learning skills and

developing an emerging social identity. The life of a college student is a process rather than just an experience and there is no doubt that for many this is a painful process [6].

As observations show, colleges and universities in the United States are becoming increasingly aware of a need for a service which would help the students, especially in preserving and enhancing their mental health. It seems almost everybody is willing to agree that the college presents a natural setting for preventive mental hygiene.

In following the trend, many smaller universities in the USA have in recent years been establishing psychological services centers in the departments of psychology. Such centers have had different organizational structures and they included different professional experts. In this paper, a fairly typical psychological services center will be described which has been established in 1960 as a unit of the Department of Psychology. This center has been offering, among other services, short-term psychotherapy to students over a period of seven years. Recently, a study evaluating the work of this psychological services center, especially regarding its effectiveness in psychotherapy, has been concluded, the results of which are submitted here. Our results were related to similar studies of other centers and, therefore, comparisons of findings were also included in our study.

Psychological Services Center

The Psychological Services Center (later referred to as PSC), which I plan to describe here, is quite typical of many college campuses in the USA. It is operated as a part of the Department of Psychology. It is staffed primarily by professional psychologists, all of whom are university professors. They are given time to work in the PSC in terms of reduction of their teaching load. Since the Department of Psychology includes various sub-specialties on its faculty, all applied specialties were invited to participate in the PSC work. Therefore, among our nine staff members we have specialists representing the following subdivisions of psychology: clinical, counseling, industrial, vocational and educational guidance, and testing and measurement. Probably the most unusual aspect of our PSC is the fact that it includes a psychiatrist on its staff. The psychiatrist also teaches in the Department of Psychology and has regular faculty rank. While he does not hold an administrative position in the PSC, nevertheless, he attends our staff meetings and consults with the psychologists on all

cases including serious existing or potential emotional disturbances. Whenever necessary, he prescribes medication and supervises therapy, especially if this should require hospitalization. He represents our chief liaison with the Medical Services Center on the campus.

In order to make the services of the PSC available to the largest number of students, the staff decided to use short-term individual counseling or psychotherapy as the preferred method of treatment. We thought that since we were dealing with quite intelligent clients, we should make the best use of their insights and move our psychotherapeutic process at the maximum possible speed. It was agreed that the goal will be to complete the case in six to eight sessions, with the understanding that some cases may run shorter and some may need additional sessions. However, in cases where the therapy was to exceed eight appointments, the therapist was requested to present his case to a staff meeting in order to obtain the opinion and suggestions of his colleagues.

The study by FRANKLIN and MCLEMORE [7] as well as other studies suggest that students have a negative attitude toward student health services. This attitude usually becomes worse when mental health services are involved. Being aware of this fact, we have striven from the beginning and succeeded to maintain the PSC work primarily on a self-referral basis. The Dean of Students and his staff may refer cases to the Center, but no guarantee is given that the referring agents will receive a feedback from the PSC, unless the seriousness of the case necessitates it. Students who come as self-referrals have the guarantee that nobody will be informed of their case without their approval. To deal with general problems concerning student mental health, we have agreed to provide general consultation to deans and other administrators whenever and wherever needed. This service has been and is being utilized mostly without identifying the individuals.

Procedures of counseling

The catalogue of our University states that each full-time undergraduate student can obtain psychological services in dealing with vocational decisions (change of the major), personal problems and special problems. Students are told there that they can obtain these services upon paying the nominal registration fee of five dollars to the PSC. The rest of the services are free of charge. A student desiring the service usually comes

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to the PSC secretary who gives him an information blank to be completed and schedules him for an intake interview with the director of the center or his assistant. The purpose of the interview is to determine the type of case we are dealing with and to assign the counselor. After this, the counselor sees the student for one 50-minute interview and determines either what tests he may need or what kind of counseling he will proceed with. The counselor also decides whether the case needs staffing or a consultation with the director or another staff member. The counseling, which in our terminology includes psychotherapy, is conducted according to the orientation and professional background of the counselor. Cases needing referral or consultation are usually discussed with the director, who is a clinical psychologist, and they may be referred to the staff meeting or acted upon immediately if the situation requires.

Our study

Although the services of the PSC at Xavier University are available to the graduate students and evening college students, our primary clients are full-time day students because the others are required to pay a moderate fee for each service rendered. The services to full-time day students are partially subsidized through the student activities fee which is not applicable to graduate and evening college students. While the PSC has been in existence for over seven years at this University, it was thought that the last three years should give an adequate example of our work.

Procedure

During the period of the academic years 1964–1967, approximately 562 students were seen by our PSC staff which represented about 11 % of our total student population. This was the sample of our study. About one-fourth of the cases were drawn at random for the study which included the N of 139. Eight staff members whose cases were drawn were asked to fill in a questionnaire designed to describe each individual case (see Appendix). The answers to the questionnaire, which were completed by all psychologists involved, were evaluated statistically and the results tabulated.

Results

The distribution of our student clients according to their year of studies is presented in table I.

Table I. Distribution of student clients according to year of their studies

Year	Number of cases	Percentage of cases
Freshmen	41	29.5 %
Sophomores	40	28.8 %
Juniors	20	14.4 %
Seniors	16	11.5 %
Graduate	6	4.3 %
Unclassified	16	11.5 %
Total	139	100.0 %

According to this table, 29.5 % of our clients were freshmen, 28.8 % sophomores, 14.4 % juniors, 11.5 % seniors, 4.3 % graduate students and 11.5 % unclassified. The unclassified category had to be included due to the fact that some students were either between the usual classification of the registrar or they were transfer or return students.

Table II indicates that 61.2 % of all our clients were self-referrals.

Table II. Sources of referral

	Number of cases	Percentage of cases
Self-referred	85	61.2 %
Professor	11	7.9 %
Parent	4	2.9 %
Other (fiance, dean registrar, etc.)	17	12.2 %
Undetermined	22	15.8 %
Total	139	100.0 %

The referral by the teacher was only 7.9 %, by the parents 2.9 %, and by the dean, registrar, etc. 12.2 %. Approximately 15.8 % of the clients did not give the exact source of referral which would suggest that they too were self-referrals. This would mean that our self-referred clients represent about 77 %, which is much higher than the statistics given by WITTINGTON [12, p. 77] as 39 %. The majority of our cases – 81.29 % as shown in table III – were completed within eight sessions.

Table III. Distribution of counseling sessions

Number of sessions	Frequency	Percentage
One	7	5.04 %
Two	45	32.37 %
Three	15	10.79 %
Four	16	11.51 %
Five	8	5.75 %
Six	6	4.32 %
Seven	5	3.60 %
Eight	3	2.16 %
Other	26	18.71 %
No response	8	5.75 %
Total	139	100.00 %
One to eight sessions	113	81.29 %

Those who did not finish within this period required long-term psychotherapy and they represented 18.71 % of our cases.

As shown on table IV, 55.4 % of our student clients came to ask for help with their vocational choice.

Table IV. Initial purpose of counseling

Designation	Number of cases	Percentage of cases
Vocational decision	77	55.4 %
Academic difficulties	27	19.4 %
Reading problems	7	5.0 %
Emotional difficulties	24	17.3 %
Personal problems	31	22.3 %

N = 139; since the categories were overlapping, the percentages were computed in relation to the total N.

Of the clients, 19.4 % had academic difficulties, 5 % had reading problems and 39.6 % had either emotional or personal difficulties. These statistics were based upon the view of the problem by the client which was voiced to the counselor at the first interview.

Our procedures usually included administration of various tests. The most frequently administered tests are listed in table V. The percentages here were computed each time in relation to the total N although not all tests were administered to the same clients.

Table V. Tests administered to the clients

Test	Frequency	Percentage
Kuder Vocational Interest	95	68.3 %
Kuder Personal Interest	36	25.9 %
Kuder Occupational Interest	38	27.3 %
Minnesota Multiphasic Personality Inventory	57	41.0 %
A.V.L. Study of Values	65	46.8 %
O.S.U. Psychological Exam.	35	25.2 %
Michigan Vocabulary Test	36	25.9 %
Nelson-Denny Reading Test	29	20.9 %
Edwards Personal Preference Schedule	77	55.4 %
Differential Aptitude Test	14	10.1 %
College Qualification Test	6	4.3 %
Other personality tests	67	48.2 %

N = 139; since the categories were overlapping, the percentages were computed in relation to the total N.

The counseling direction was changed in many instances after the testing. The results of the change of counseling directions are shown in table VI.

Table VI. Direction of the counseling based upon test results and initial interview

Type of counseling	Number of cases	Percentage of cases
Vocational counseling	80	57.6 %
Personal counseling	30	21.6 %
Short-term psychotherapy	22	15.8 %
Long-term psychotherapy	14	10.1 %
Referred to	5	3.6 %

N = 139; since the categories were overlapping, the percentages were computed in relation to the total N.

According to this table, 57.6 % became vocational counseling cases while personal counseling and psychotherapy was needed in 47.5 % of the cases. At the same time, 3.6 % of the cases were long-term and serious cases which we referred to outside agencies for long-term therapy.

The counselors were asked to describe the results of their work with the client and their answers are presented in table VII.

Table VII. Results of the counseling as indicated by the counselor's notes

Description	Number of cases	Percentage of cases
Determination or change of major	67	48.2 %
Improvement of study patterns	27	19.4 %
Insight into personal problems	49	35.3 %
Reduction of emotional tension caused by anxiety, guilt, lack of self-confidence	41	29.5 %
Improvement in peer relations	14	10.1 %
Better sexual adjustment	11	7.6 %
Prevention of serious emotional difficulties (such as suicide, severe aggressive acts, depression, nervous breakdown, etc.)	16	11.5 %
Taking up different nonacademic career	5	3.6 %
Continuation of academic work	19	13.7 %
Dropping out of college	3	2.2 %
No results	2	1.4 %
Hospitalization of the client	1	0.7 %
Other	5	3.6 %

N = 139; since the categories were overlapping, the percentages were computed in relation to the total N.

According to their answers 48.2 % of the students decided to change their major, while 19.4 % improved in their study patterns. While 35.3 % gained better insight into their problems, 29.5 % of the clients showed reduction of tension, anxiety, guilt and feelings of inferiority. In 11.5 % of the cases serious emotional problems, such as suicide, nervous breakdown, severe aggressive acts, etc., were prevented. Only 0.7 % required hospitalization and 2.2 % had to discontinue their college work. Table VIII describes the staffing procedures of our cases.

Table VIII. Staffing of the cases or consultation

Action	Number of cases	Percentage
Staffed	25	18.0 %
Not staffed	114	82.0 %
Consulted with colleagues	45	32.4 %
Not consulted with colleagues	94	67.6 %
Medical or psychiatric consultation	16	11.5 %

Only 18 % of our cases were staffed, but 32 % were discussed with other colleagues and 11.5 % included psychiatric consultation. This incidence should also be referred to the statistics on table VII which indicates that exactly the same percentage of cases was diagnosed as having serious mental health difficulties. The counselors were asked to judge whether in their opinion such short-term psychotherapy served its purpose. Their answers are presented in table IX.

Table IX. Counselor's judgment concerning the outcome of the case

The outcome	Number of cases	Percentage of cases
Helped	102	73.4 %
Not helped	12	8.6 %
Uncertain	20	14.4 %
Should have been handled differently	0	0.0 %
No reply	5	3.6 %
Total	139	100.0 %

The majority of cases (73.4 %) were judged as having been helped by this procedure; in 14.4 %, the therapists were uncertain, and in 12 cases, which represented 8.6 %, they saw no improvement.

Our staff did not subscribe forcibly to a special school of thought in therapy. As table X indicates, in 17.3 % of the cases the non-directive approach was used, while 40.3 % of the individuals were dealt with using the vocational-guidance method. Psychoanalytic therapy was used in only 2.2 % of the cases, while the eclectic approach was applied in

Table 3. Description of psychotherapeutic preferences: their frequencies and percentages

Type of psychotherapy	Number of cases	Percentage
Non-directive	24	17.3 %
Eclectic	36	25.9 %
Existential	9	6.5 %
Vocational guidance	56	40.3 %
Psychoanalytic	3	2.2 %
Learning and behavioral therapy	14	10.1 %
Other	2	1.4 %

N = 139, since the categories were overlapping, the percentages were computed in relation to the total N.

25.9 % of the cases. Other approaches used included: existential 6.5 %, learning and behavior therapy 10.1 %, and unclassified 1.4 %. The analysis of data in applying the point by serial correlation did not indicate that one method was superior to the other. The comparison of the therapist's orientation, such as non-directive, psychoanalytic, eclectic, etc., and the success of psychotherapy was evaluated in a pointbiserial correlation and the coefficients of the correlations varied from 0.008 to 0.190. None of the seven correlations was statistically significant. Basically, it was the therapist, not his method, which apparently represented the variable of therapy success.

Discussion

According to the US national statistics [3] 0.1 % of our population is expected to attempt suicide and 0.0125 % commit suicide. Our rate of serious emotional disturbance was 11.5 %. During the period of our study, no actual suicidal attempt took place among our students, although according to national statistics, we could have expected about five incidents in the population of 5100 students. Other universities have met more than national statistics. Were we lucky or was this due to our counseling services? I would like to think that our PSC prevented five suicide attempts, but there are other factors which should play a part in our setting. Our undergraduate student body is predominantly Roman

Catholic and it is quite possible that the religious convictions helped here. Besides our PSC counseling services, our students receive a great deal of personal counseling and attention from faculty members other than the psychology staff which undoubtedly serves its function. On the other hand, most of our students (99 ¾) are male who, according to statistics, are four times more prone to suicide than females (4), which means that our lack of suicide is an even more meaningful fact.

The question as to whether or not our services were effective and to what extent cannot be answered without a follow-up study. We included only the counselors in our study. There would be a need for clients' evaluation to make the facts more realistic. However, a careful study conducted by WITTINGTON [12], which included a follow-up, provides strong support that the therapist's judgment concerning the case is more reliable than the judgment of the patient. For example, in WITTINGTON's study, the counselor estimated the improvement in cases of 54 ⅓ of the male patients, while the patients themselves reported improvement in 75 ⅓ of the cases. The no-improvement report of the therapist was 45 ⅔ and that of the patients was 46 ⅔ [12, p. 169]. Since the return of the follow-up questionnaires seldom exceeds 50 ⅓ of the cases, the patients' evaluation is even more tenuous. On the basis of this, it was assumed that our study of the counselor-therapists' responses was very probably as valid or even more valid than the results of a follow-up study using the answers of the patients. Accordingly, while a follow-up may have strengthened our study, its validity can be defended without the follow-up.

The results indicate that our setting provided valuable service to the students and possibly preserved their mental health. If the judgment that we have helped 73 ⅓ of our student clients is true, the service was more than justified. If the 11.5 ⅓ of the clients were prevented from serious emotional breakdown, our facility was very efficient. The fact that no suicide attempt took place on the campus during this period of time may suggest that we may have contributed to its prevention.

Prevention and cure

The question which could be raised in relation to the psychological services described and to similar services for college students at other universities concerns its purpose. Does this service help to prevent more serious difficulties or does it actually cure emotional disorders? Should

a short-term psychotherapy be considered a worthwhile investment for a university community? My answer to this, based upon our survey, would be definitely a positive one. CARL ROGERS [10] suggested a non-directive therapy with college students because among other things he thought that they were intelligent enough to find their own solutions to problems with some professional help. Short-term psychotherapy which we have applied showed that with some direction, college students can use their intelligence to gain insight and grow emotionally as quickly or slightly more quickly than the cases treated using the non-directive approach. It is a fact that in our modern, complicated way of living people need counsel and advice, and it is quite possible with a proper psychological approach to provide such counsel and advice. In view of the shortage of trained personnel, short-term counseling and psychotherapy may prove to be the main service for the prevention and cure of mental health problems with college students. Probably the most important aspect of such a service is and will be that it has to be wanted by the clients. Our study suggests that in an appropriate setting most students are willing to utilize psychological services. Our basic philosophy has been in favor of short-term individual rather than long-term group psychotherapy. College students are still at the age where a one-to-one relationship is very important and where they may share their problems more easily in individual therapy, but may refrain from doing so in groups. While I agree that social experience and group experience is a very important part of the college life, I do not think that it should be the main goal of psychotherapy to provide such experiences. College fraternities and sororities do a much better job at less expense. Individual psychotherapy, even of short duration, can provide the student with insights and ideas how to cope with his drives, how to direct his incentives and deal with his motives. The rest is up to the student to follow [1]. The experience shows that an intelligent person can continue coping with his difficulties if given proper direction or set on the right track. While it is impossible to quantify all the data statistically, our clinical reports include numerous cases where two or three interviews were sufficient to provide a cure to sometimes very serious problems. We have records where complete remission took place after one therapy session. I could quote cases where suicidal tendencies disappeared completely after three or four sessions; homosexual panic was resolved in five sessions and the identification crisis was prevented. The point in all of our cases is that we have tried to consider them as a problem-solving process where the therapist and the client were

equally involved. They could both solve problems in most instances in a short time. They could both also make proper plans to prevent problems. Our short-term psychotherapy based upon this philosophy has been quite successful, both quantitatively and qualitatively. According to my thinking, psychotherapy in a college setting becomes nothing more and nothing less than part of college experience needed more by some students and needed less by others. Very likely those who need it are as good students and as valuable future citizens as those who do not. Those students who need psychotherapy deserve to receive it as other regular services rendered by the universities for prevention and for cure in many cases. Our model is one of many, but I expect our experience soon will be universal at all universities. I believe that short-term psychotherapy will be the most efficient approach for prevention and cure of emotional difficulties in college students.

Summary

The need for psychological services for college students is gaining universal recognition. Several approaches to providing such services were discussed and the usual patterns used in liberal arts colleges in the USA for such services were described. A study of the experiences of eight professional psychologists involved in a psychological services center rendering short-term individual psychotherapy to students was conducted and statistical description of the results presented. The findings were discussed and the value of short-term psychotherapy for prevention and cure of adjustment difficulties among college students indicated.

Appendix

Counselor: _____

Student's Name: _____

1. Year: (A) Freshman____ (B) Sophomore____ (C) Junior____ (D) Senior____ (E) Graduate____

2. Referred by: (A) Self ____ (B) Professor ____ (C) Parent ____ (D) Other ____

3. Dates seen: _____

4. Number of sessions: (A) 1 ____ (B) 2 ____ (C) 3 ____ (D) 4 ____ (E) 5 ____
(F) 6 ____ (G) 7 ____ (H) 8 ____ (I) other____ (please indicate)

5. Initial purpose of Counseling: (5) Vocational decision ____
(6) Academic difficulties ____ (7) Reading problems____
(8) Emotional difficulties____ (9) Personal problems ____

6. Tests administered: (10) Kuder Vocational Interest ____
(11) Kuder Personal Interest____ (12) Kuder Occupational Interest____
(13) M.M.P.I.____ (14) A.V.L. Study of Values ____
(15) O.S.U. Psychological Exam.____ (16) Michigan Vocabulary ____
(17) Nelson-Denny Reading Test____ (18) E.P.P.S.____ (19) D.A.T.____
(20) C.Q.T. ____ (21) Other____

7. Direction of Counseling Based Upon Test Results: (22) Vocational Counseling ____
(23) Personal counseling ____ (24) Short term Psychotherapy ____
(25) Long-term Psychotherapy ____ (26) Referred to____

8. Results of Counseling: (27) Determination or change of major ____
(28) Improvement of study patterns____ (29) Insight into personal problems ____
(30) Reduction of emotional tension caused by anxiety, guilt, lack of self confidence____ (31) Improvement in peer relations ____
(32) Better sexual adjustment ____(33) Prevention of serious emotional difficulties (such as suicide, severe aggressive acts, depression, nervous breakdown, etc.)____
(34) Taking up different nonacademic career____
(35) Continuation of academic work____ (36) Dropping out of college____
(37) No results ____ (38) Hospitalization of the client ____ (39) Other ____

9. Type of counseling or psychotherapy used: (40) Non-directive ____
(41) Eclectic____ (42) Existential____ (43) Vocational-guidance ____
(44) Psychoanalytic____ (45) Learning and behavioral therapy____
(46) Other ____

10. Staffing of the case: (47) yes ____ (48) no ____

11. Cousultation with colleagues: (49) yes ____ (50) no ____

12. Medical or psychiatric consultation: (51) yes____ (52) no ____

13. In retrospect, do you think this case was helped? (53) yes ____ (54) no ____

(55) Uncertain ____ (56) Should have been handled differently____

14. Your opinion concerning the value of short-term counseling in such cases as this:

_____

Thank you for your co-operation.

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Milieu Control: An Aid in the Psychiatric Treatment of Adolescent Underachievers

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This paper is a report on the experimental control of the psychosocial milieu to facilitate the psychiatric treatment of adolescent underachievers at The Readjustment Center, Ann Arbor, Michigan. This is a unique residential facility. We specialize in the psychiatric treatment of adolescents in junior and senior high school who have the symptom of scholastic underachievement. We select intelligent middleclass adolescent males who are primarily neurotic underachievers. We do not work with those whose underachieving stems from problems of delinquency or who are borderline or psychotic. Our treatment orientation is psychoanalytic and all patients are in individual therapy.

The staff of this residential facility has gradually evolved over the years in such a way as to create that type of psychosocial milieu that has seemed to be most helpful and effective in the psychiatric treatment of underachievers. There are three functional levels: the Board of Directors, the Center staff, and the University student trainees, referred to as 'junior staff' by the patients. The Head of the Board of Directors, an attorney, is the ultimate administrative authority. Patients see him by appointment at his office in downtown Ann Arbor. A patient may consult him in an effort to get an important Center rule changed. Or, the patient may be referred to him by the Center staff for chronic serious problems there. He is never at the Center. A visit to him may stir up considerable anxiety that can be used in a therapeutic way, as he has the authority to discontinue the treatment program if this is indicated. This administrative arrangement has three advantages: it provides a court of appeal that transcends the Center staff; secondly, the patient's hostility stemming

from important decisions not to his liking is centered on the Board of Directors rather than the Center staff; and finally, a conference with the Board of Directors can be used in such a way as to generate anxiety in the patient. Recommendations are made to him by the Center staff and the psychiatrist. The Center staff is completely involved in the day-to-day administration. They provide ego support, loan ego controls if needed, and are involved in setting limits and making restriction of privileges. The Center staff is directly involved in all aspects of the patient's living, including the channeling of his energies in the direction of school and study and other activities. The third level, the University students, have no administrative function. They cannot restrict. Their important and narrow task is to make friends with the patients and help where help is needed and wanted by the patient. These functional differences in the three levels of staff are derived from trial and error experience over a period of years. They are reviewed here briefly.

The psychiatrist has no direct administrative function in the Center operation and is not directly concerned with such staff problems as encouragement of school attendance and study, for example. He can do his work best if he remains outside the staff organization and divorced from all administrative problems. To the patients, he is simply their therapist. He must not wear two hats, and be both therapist and administrator. However, he is in daily consultation with the staff and is aware of the patients' problems and progress via reports from both Center and school. Without revealing confidences, he helps the staff understand the patient's problems and behavior. He sets the overall tone or philosophy of the Center so as to provide an atmosphere that fosters the patient's working through his problems.

Adolescents come to the Center not for schooling but for treatment of the underlying conflict that blocks their learning process and their school advancement. We regard underachieving as a symptom, as a reflection on the outside (in the area of performance) of conflicts on the inside. Underachievers may be divided into two groups. In the first group, the diminished ability to learn stems from the excessive expenditure of mental energy in non-learning areas and an inadequate supply is available for the ego function of learning. This is by far the larger group and is made up of two subgroups. First are those students who are preoccupied with disturbances in their relationships *with others:* parents, siblings, or peers, and their attention is focused on *these* problems rather than on the subjects to be learned in class. They may get into trouble and be unable

to learn at their potential because of the displacement of feelings from parents to teachers or from siblings to classmates. Secondly, there are other students in this first group who are troubled with emotional reactions involving primarily *themselves,* such as feelings of shame, insecurity, guilt, fears of various kinds, or engrossments in fantasies or daydreams of a wide variety. This first and larger group of underachievers requires less intensive treatment and the prognosis is usually good. Many problems resolve themselves in time because they are inherently transient, or because the external family situation changes. Once the acute stress is over, the problem of underachieving may be dissipated.

The second group of underachievers is made up of those students in whom the learning process itself has been involved in a psychic conflict. This small group requires intensive, analytic therapy to get at the unconscious roadblocks to learning. Usually, this takes two or three years of residential treatment and sometimes longer. This latter group is the type of adolescent underachiever with whom we work at The Readjustment Center.

Several years ago, we had the problem of the formation in our population of underachievers of a small subgroup of adolescent whose negative attitudes towards school and learning had a harmful effect on the group as a whole, and tended to reinforce the negative side of the usual ambivalent attitudes towards school and learning. Some respect accrued to these hardcore underachievers on the basis of their older age and greater strength, and made the social milieu less conducive to positive attitudes towards ego accomplishments, such as school attendance and learning. As a result of these experiences, we decided to deliberately attempt to control the psychosocial milieu and considered ways to facilitate the therapeutic process and the resolution of the neurotic conflicts. Our goal was to develop the optimal condition for psychotherapy. We had learned from bitter experience about 'attitudinal contagion' with our subgroup of hardcore underachievers. We had to terminate their treatment. We noted a negative influence on the therapeutic progress of the rest of the group because the overall influence was toward a negative view of school, community, and the adult world. Therefore, we began experimenting with a deliberate *seeding* into our group of several student underachievers who needed residential treatment primarily for other symptoms, and who we felt quite certain would soon be able to excel in school. Their difficulties were those typical of the *first type* of academic underachiever, characterized by the excessive loss of mental energy in

ego functions that were not involved in a psychic conflict centered on learning. We selected these patients on the basis of three factors: age, size, and the nature of their conflict. The preferred characteristics for this purpose, we found to be eleventh or twelfth graders who can gain the respect and admiration of the group on the basis of their being older, stronger, and basically good achievers. The third factor concerns the nature of the emotional difficulties. The optimal choice is one in which the patient has a conflict of a nature that does not produce primarily withdrawal symptoms, or a defensive hostility to the environment. It is a specific kind of person required for this function. They are troubled, and need intensive treatment for problems other than those associated primarily with achieving. In that they are 'sick' and in treatment lies the common denominator that facilitates their use by the other underachieving patients as objects for identification and emulation. They escape the hostility of the bright, older brother or the 'all-American boy' type, so often exalted by the parents, through the sharing with the group of the common bond of being a patient in treatment. We have found the presence of these selected achievers in the group to be of value. It thwarts the growth and spread of anti-school and anti-learning attitudes which in earlier years tended at times to be reinforced and propagated by the few dominant hostile underachievers.

At the present time, we are also experimenting with a *second type* of deliberate milieu control in association with the University of Michigan and Eastern Michigan University. This is a course offered for upperclass University students who receive credit toward graduation for working with the underachievers at The Readjustment Center. The group is made up of carefully selected students who are interested in tutoring and who can spend several hours a week at the Center with the patients. We arrange one University student tutor for each patient and encourage the paring off of student and patient on the basis of mutual attraction and friendship, after several hours of exposure during the first few visits to the Center. We feel that this one-to-one relationship is very helpful. The University student's attention is exclusively focused on one patient and not diluted by a group. This increases both the patient's self-esteem and his capacity to communicate with the University student whose attention is focused solely on him. We advise and counsel the University students on their conduct and work with the patients, and outline the errors to avoid. We want to develop the optimal conditions for psychotherapy so that the therapist can focus on the neurotic conflict of the patient and

not gent involved in the administrative matters of school attendance and study. We felt that a major pitfall to be avoided was the type of attitudes that many of our group of underachievers had been subjected to by their parents: excessive pressure to be 'good' and 'to learn', to 'study hard' and to 'achieve high grades' in school. These parental admonitions are avoided by the University students. After a good relationship has been established, the University student may say to the underachiever, 'Do you want me to help you with your assignment', or, 'Can I help you with your homework now'. Or, in other instances, we advise that the University student simply offer to sit and study some of his own homework with the underachiever, or perhaps to just be content with a general conversation with the underachiever. A second pitfall we are wary is that the University students avoid the contamination of the universal ambivalence to teachers by referring to themselves as simply University students or student assistants. Teachers must be on the side of the ego function of learning and, therefore, frustrators of the instinctual drives. Students often view their teachers as the ultimate representations of the oppositional force of the adult world. We want to disassociate these attitudes from the University students so that there will be less ambivalence in the relationships, and a tendency to foster the wish on the part of the patients to please the University student by doing his homework and achieving in school. Eventually, it will lead to learning for his own sake, for the 'love of learning', which is the ultimate goal. The University students are cautioned not to require any definite accomplishments, and to expect the experiencing of frustrations from their 'patients'.

Since these patients are still in the age of academic advancement, if they are ever to attain a good career, it is extremely important for the therapist to stay out of the picture as concerns school attendance and study. If he gets involved in this problem of attendance and study, he reinforces the negative transference aspects in his relationship with the patient, and all is lost. These milieu controls relieve the therapist from being involved with the school problems until such problems are brought up with him by the patient. The channeling and encouragement of the patient to attend school, to study and achieve, comes from the staff, and not from the therapist. The encouragement to help is then from the University students in the form of 'can I help you' offered in a different way than experienced by the patient in the earlier years with his parents.

Conflicts centering on attendance and study often become a very important part of the treatment situation. Progress in therapy is often reflect-

ed in the patient's growing awareness that his inner conflicts have found their expression in scholastic underachievement or non-attendance, or both. The therapist can treat this as a symptom, without involvement in the administrative staff function of encouragement to attend school and study.

We then hope to achieve these two goals: first, the milieu control so as to develop the optimal conditions for psychotherapy, and secondly, the avoidance on the part of the therapist of any involvement with the administrative problems of school attendance and study. These we feel are staff functions. The therapist must remain neutral and not participate in any of the necessary requirements regarding school attendance and study.

We feel that the good results noted to date in this experimental program designed to alter the milieu in the direction of positive attitudes towards school and learning for the ultimate goal of facilitating the therapeutic process, stem from several factors. First is the planned arrangement of an overall atmosphere that is conducive to learning. There is no repetition of the parental admonitions and threats and pressures. These are carefully avoided by the staff and the University students. We want to avoid the overall feeling of coercion that has been experienced by some patients in the past. Secondly, we utilize the adolescent's wish to identify with and emulate older young people. We provide members of an age group intermediate between themselves and their parents. The three- to six-year age differential between them is an asset in terms of encouraging the formation of ego ideals among this group of established academic achievers. Our patient group is aware of the high University entrance requirements. We have found that the subtile process of 'attitudinal contagion' stemming from the personal relationship established and the exchange of views, is of importance and value to our underachieving patients. Their attitudes may be altered through the process of identification and the wish to emulate the frequently somewhat idealized, University student. Thirdly, we hope that the patient may in time develop an attachment to the University student that may lead to his wanting to study in order to please, or to not displease, the helping University student. We deliberately utilize these natural tendencies to 'learn for love' as they may develop in these relationships with University students. We know that long before the child reaches school age, he has had many thousands of learning experiences that have been motivated by the wish to retain the parent's love. We know that this is transferred to school teachers later on.

At the elementary level in school, the child learns in large measure for love, the love of the teacher. Later in high school and college, this gradually is changed from 'learning for love' to the 'love of learning'.

Very often, the adolescent underachiever who is living at home creates secondary problems with parents and teachers, and these secondary problems usually become the arena of conflict. The primary difficulty is no longer in focus. It is overshadowed by the secondary conflict between the patient and his parents centered on school attendance and study. This is a projective device, getting the inner conflict that is expressed in underachieving externalized and dealt with as a conflict between the parents and the child. The patient thereby avoids the inner anxiety. (He gets involved in conflicts with parents or school in which there is a great deal of projection and rationalization.) The whole problem is seen as a parent–child conflict. It is similar to the problem of getting the school phobic child back in class (in the area that stirs up his anxiety) so that we can then deal with the inner anxiety and not get involved in the outer fight with the parents or other authorities over school attendance.

As a result, many parents bring their adolescent underachiever to the Center with the expectation that the primary direction of his treatment will be the enforcement of some kind of discipline, as one would expect at a military school. They do not realize that this would merely foster further resistance. Our job is to resolve the inner conflict so that the adolescent can move ahead with his own inner motivation. The center's efforts at milieu control facilitate the problem of getting things back where they belong, in the mental life of the patient. It is the therapist's job then to help the patient understand why he needs to be an underachiever or to skip school or both. The answer must be found inside the patient, not in the milieu changes. The latter facilitate treatment by helping the patient get involved in attending school and studying and these are the activities that stir up his anxiety. The ultimate nucleus of the problem lies in the patient's anxiety, and this can stem from a number of causes, as discussed in an earlier paper. Patients avoid this anxiety by underachieving or by skipping or by dropping out altogether. The anxiety may relate to fears of separation, fears of castration, fears of their own aggression, the fear of acquiring a certain identity, or the need to avoid a certain identity. Or, the fear of being found out or exposed in class as being stupid or defective or feminine, on the one hand, or the fear of being seen as too bright, too competent and successful on the other hand. These are a few examples of some of the types of anxiety that cause the symptom of under-

achievement and truancy of dropout. We are merely mentioning here some of the types of anxieties, which with more time, could be dealt with more thoroughly. The therapist has the job of analyzing the anxieties and helping the patient work through the problem, so that he can deal with himself in realistic terms, rather than in the out-dated and distorted or magnified scale of the original early childhood conflicts.

We feel that these milieu controls are an effective method of facilitating the treatment process, and of making the therapist's job an easier one.

In summary then, we structure the psychosocial environment in a certain way because we are dealing with a specific problem of scholastic underachievement. First, we seed the group with older respected achievers who are also in treatment for symptoms primarily other than learning problems. Secondly, we provide ego ideals and objects for identification and emulation of a specific type: not young mechanics or athletes, but young University students. They are carefully instructed and able to relate in a friendly, non-pressuring way. The aim of this experimental milieu arrangement is to facilitate the therapeutic process and the resolution of the neurotic conflicts that form the nuclear basis for the need to underachieve and/or avoid school.

It is interesting to speculate on the broader applications of this method of milieu control in a program designed for those many thousands of underachievers who have finished their schooling and are now underachievers in life: without specific job training and without any goal or purpose. The problem of underachieving is not necessarily a neurotic one, as it is found often in the culturally disadvantaged colored population in the States. Frequently, the fathers of these students have achieved nothing and often have criminal records. The mothers are usually more stable but often work outside of the home. Thus, the student has little offered to him in the form of an adequate male with whom to identify, and little contact with men of his own race who might serve as ego ideals. Furthermore, the student may feel, with some justification, that he has little chance in the white man's world and may end up with the attitude of 'why try'. He may see no point in it if there is little hope of succes. In the States, the Federal Government is spending large sums of money for programs of job training. In spite of the heavy expenditures, the achievement ratio remains low. This stems in part from the presence of neurotic underachievers. For them, external psychosocial control with the arrangement such as I have described in this paper would, by itself, have

little value. They would require intensive analytic therapy. On the other hand, for the non-neurotic type of underachiever such as some of these culturally disadvantaged groups whose difficulties are the reflection of social problems rather than intrapsychic conflicts, such milieu control, especially the seeding of older respected achievers into the group, would have definite value in insuring the success of these job training programs.

Summary

A report is given on the control of sociopsychological milieu to facilitate the residential treatment of scholastic underachievers. The underachiever group was seeded with respected achievers, who are also patients in treatment. University of Michigan upper-classmen were appointed as student teachers to serve as ego ideals and objects for identification and emulation. 'Attitudinal contagion' and 'learning for love' are noted.

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Struktur und Funktion eines studentischen Gesundheitsdienstes

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In einem willkürlich herausgegriffenen Quartal der Göttinger Studentischen Krankenkasse wurden Ärzte und Polikliniken aller Fachrichtungen von 16 % der Studentenschaft aufgesucht. In einer Rangreihe der Häufigkeit standen die praktischen Ärzte an der Spitze, es folgten Internisten, Haut- und Augenärzte, jeweils etwa gleich oft vertreten (15 %). Werden die Krankenscheindiagnosen, lediglich der praktischen Ärzte, Internisten und Nervenärzte, auf ihren Anteil sogenannter funktioneller Beurteilungen wie «vegetative Dystonie, Erschöpfungszustand, Neurose» berücksichtigt, so finden sich bereits in 15 % Diagnosen primär nicht organischer Störungen. Addieren wir die Diagnosen chronischer Magen-Darm-Symptome mit 7 %, so ergibt sich bereits ein Anteil wahrscheinlich psychisch oder psychosomatisch gestörter Studenten von mindestens 22 % der Arztbesuche in einem Quartal, zu denen etwa die Hälfte studentischer Augenarztpatienten wegen ausschliesslich funktioneller Störungen und der überwiegende Anteil der Hautarztbesucher unter psychosomatischem Aspekt hinzugefügt werden können. Die relative Häufigkeit von Haut- und funktionellen Augenstörungen bei Studenten ist psychosomatisch interessant. Sie korrespondieren mit der sogenannten schizoiden Persönlichkeitsstruktur und weisen auf eine sehr frühe seelische Schädigung hin. Die erhebliche Zunahme dieser Persönlichkeitsstruktur mit den Geburtsjahrgängen des Zweiten Weltkrieges konnte nachgewiesen werden [Hau]. Ihr Hauptmerkmal ist die emotionale Unvertrautheit mit der Welt.

Besondere Beachtung verdient auch das Selbstmordproblem bei Studenten: Nach amerikanischen Untersuchungen (Berkeley-Studie) liegt die Suizidhäufigkeit bei ihnen um 77 % höher als bei der altersentsprechen-

den sonstigen Bevölkerung. Bei ersten eigenen Forschungsansätzen über Selbstmordversuche bei Studenten fiel auf, dass alle tödlich verlaufenen Fälle in den Journalen der Medizinischen und Nervenklinik nicht als Patienten verzeichnet sind. Die günstig ausgegangenen Selbstmordversuche – mindestens zehnmal häufiger – waren dagegen durchgängig rechtzeitig bemerkt worden und in klinische Behandlung gekommen. Soweit Nachuntersuchungen vorliegen, zeigten sie, dass gravierende Vorstellungsirrtümer über die Realität vorlagen, die irrational hartnäckig verteidigt wurden.

Über die Häufigkeit psychischer Störungen bei Studenten liegen, je nach Standort, unterschiedliche Schätzungen vor. Nach einer bei uns laufenden Stichprobenuntersuchung zur psychosozialen Lage von Germanistik-Studenten – dieses Massenfach hatte sich bei Vorerhebungen als besonders konfliktreich erwiesen – steht ein recht hoher Prozentsatz Gestörter und potentiell Gefährdeter zu erwarten: Nahezu die Hälfte, wenn man Entwicklungs-, psychoneurotische und psychosomatische Störungen sowie neurotische Verhaltensanomalien, also Perversionen, Verwahrlosungen und Charakterneurosen zusammenfasst.

In die seit 1966 in Göttingen eingerichtete ärztlich-psychologische Beratungsstelle für Studierende kamen in einem Jahr 2,2 % der Studenten, nahezu ausschliesslich mit schweren Neurosen. Der Unterschied Patient–Nicht-Patient scheint vorwiegend in dem Ausmass der Kompensationsmöglichkeiten neben dem Studium zu liegen.

Es kann also geschlossen werden, dass psychische und psychosomatische Störungen eine wesentliche Rolle unter den Gesundheitsstörungen der Studenten spielen, oft ohne als solche erkannt zu werden. Weil das Erreichen der Gefährdeten wegen deren Scheu, Vorurteil und Widerstand so schwierig ist, sollte die Psychiatrie, auch unter psychohygienischem Aspekt, in die studentischen Pflichtuntersuchungen mit eingeschaltet werden. Art und Häufigkeitsverteilung von Gesundheitsstörungen bei Studenten lassen es nicht mehr vertretbar erscheinen, dass ihre, gerade auch im Hinblick auf das Studium, wichtigsten Störungen übersehen werden. Es ist zu fragen, ob nicht ein Psychiater überhaupt die Allgemeinpraxis des Studentenarztes betreiben sollte, wie es an verschiedenen Orten geschieht. Er könnte dann im Bedarfsfalle andere Fachdisziplinen hinzuziehen.

Die schon von FREUD vorausgesehenen «zukünftigen Chancen» konfrontieren die Psychoanalyse zunehmend mit dem Problem der grossen Zahl. Mit dem Erkennen der Störungen stellt sich zwangsläufig die Frage nach dem weiteren Prozedere: In der Regel der Hinweis auf ein seelisches

Problem und das Verweisen auf die Beratungsstelle. Zunächst kann dazu gesagt werden, dass die an etwa 40 % der Hochschulen der Welt eingerichteten speziellen psychohygienischen Beratungsstellen für Studenten sich bewährt haben, um so mehr, je grösser ihr Behandlungsangebot war. Eine reine Überweisungspraxis hat eine relativ grosse Verlustquote zur Folge, einmal wegen der Auslastung der niedergelassenen Psychotherapeuten mit langen Wartezeiten, zum anderen wegen der Finanzierungsfrage: Die studentischen Krankenkassen gewähren nur in Ausnahmefällen Zuschüsse für private Psychotherapie.

Die optimale Besetzung derartiger Beratungsstellen dürfte mit einer Zusammenarbeit von Psychiater, Psychologe und Soziologe, alle psychotherapeutisch geschult, gegeben sein. Grob orientierend fallen dem Psychologen vorwiegend die Entwicklungs- und Arbeitsstörungen, dem Psychiater die psychoneurotischen und psychosomatischen Krankheiten zu. Der Soziologe hätte die Aufgabe des dringend notwendigen «social work» zu betreiben. Eine der Hauptaufgaben eines studentischen Gesundheitsdienstes ist – wie schon erwähnt – das Auffinden und Erreichen Gestörter, wozu noch viel soziale Feldarbeit erforderlich ist.

Was kann eine Beratungsstelle – auch unter dem Zwang der grossen Zahl – psycho- und soziotherapeutisch tun? Ich meine, sie sollte mit ihren Patienten den Versuch unternehmen, einen Auseinandersetzungsprozess in Gang zu bringen und für den sozialen Hintergrund, die Universität, in Gang zu halten. Dieser individuelle und allgemeine Auseinandersetzungsprozess hätte sich immer wieder an den Fragen «könnte man etwas nicht auch anders sehen?» und «könnte es nicht auch anders sein?» zu orientieren. Er sollte bereits mit dem Erst-Interview beginnen und in allen weiteren Massnahmen vorhanden sein. Als hierfür geeignetes Hauptinstrument hat sich bei uns eine offene Orientierungsgruppe bewährt. Sie vermeidet längere Wartezeiten und hat sowohl ergänzende diagnostische und prognostische als auch bereits therapeutische Funktionen. Sie ist relativ schnell aufnahmefähig, was wichtig ist, weil persönliche und soziale Aktualgefährdungen bei Studenten eine besondere Rolle spielen. Sie fängt auf und sortiert gewissermassen nach Prognosekriterien: Einige Patienten mit ideologisch fixierten Abwehrsystemen werden sie gefestigt in ihrer Abwehr kopfschüttelnd bald verlassen, einige Hysteriker gehen ebenfalls schnell wieder, weil schon alles gut ist. Zwangsstrukturen werden gerade in der Gruppe aufgelockert, beunruhigt und damit auseinandersetzungsbereiter, Schizoide können sich erstmalig so etwas wie Kommunikation vorstellen lernen, ohne schon zu grosse Intimität fürchten zu müssen. Uner-

lässlich scheint eine Vorbereitung der Patienten auf die Gruppe in mehreren Einzelsitzungen zu sein. Ausserdem ist eine Abwandlung der Behandlungstechnik erforderlich. Die in der offenen Gruppensituation nur lokkere Kohäsion der in grösserer Zahl anwesenden Mitglieder erfordert eine bestimmte Aktivität des Therapeuten. Er macht schnell auf Interaktionsstile und Verhaltensschablonen aufmerksam, verbreitert durch Fremdbeispiele, weist auf Abwehrformen hin und bleibt mit seinen Äusserungen ausschliesslich in der Ich-Ebene. Er kanalisiert aggressive Bereitschaften und zentriert sie teilweise auf seine Person. Gelegentliches eingehenderes Hinweisen mit psychagogischem Akzent kann die Dynamik aktivieren. Es ist kein Zufall und zu diskutieren, dass gerade von langjährig tätigen Hochschulpsychiatern die Notwendigkeit des vermehrten Ansprechens auf Realität und Vernunft hervorgehoben wird, obwohl die Tendenz zur Intellektualisierung bei Studenten durchaus gesehen wurde.

Wichtig ist bei der offenen Orientierungsgruppe vor allem die Beachtung der Kontraindikation: Depressive Patienten, in deren Genese die Geschwisterrivalität eine wesentliche Rolle spielt, sollte man zunächst nur einzeln behandeln.

Aus dieser offenen Gruppe mit fluktuierenden Teilnehmern kristallisiert sich die geschlossene analytische Gruppe heraus, die den Patienten im Laufe eines Dreivierteljahres so weit bessert, dass er entweder keine Hilfe mehr benötigt oder so weit gestärkt ist, dass er sich unter nunmehr wesentlich günstigeren Voraussetzungen um einen Analyseplatz bemüht.

Jedes Mitglied der offenen wie auch der analytischen Gruppe sollte Gelegenheit zu einigen Einzelgesprächen haben. Die Orientierungsgruppe in Kombination mit wenigen Einzelgesprächen im Sinne der Fokaltherapie erscheint uns als die bisher beste Bewältigungsform der grossen Zahl. Ausserdem helfen bei angstneurotischen Manifestationen entspannende und desensibilisierende Verfahren auf lerntheoretischer Basis sowie bei Arbeitsstörungen Unterweisungen in Arbeitstechnik, meist in Verbindung mit der Gruppenbehandlung.

Erwähnen möchte ich noch, dass bei uns ältere, an der Psychotherapie interessierte Studenten und Doktoranden der einschlägigen Fächer im Sinne des «social work» tätig sind. Sie erheben soziale und biographische Anamnesen, haben einige Betreuungspatienten unter Kontrolle und machen, das scheint mir sehr wichtig, gelegentlich Hausbesuche bei suizidgefährdeten Studenten und einigen Behandlungsabbrechern. Es verdient Hervorhebung, dass sie von ihren Kommilitonen bisher immer akzeptiert wurden. Schliesslich ist die enge Zusammenarbeit sowohl mit

der psychiatrischen als auch mit der Neurosen-Fachklinik unerlässlich; ob eine Spezialklinik ausschliesslich für Studenten besondere Vorteile bieten würde, müsste diskutiert werden.

Betrachtet man zusammenfassend die unseres Erachtens optimale Struktur eines studentischen Gesundheitsdienstes, so ist auch gleich seine Funktion mit umrissen: Er soll den Charakter eines Netzwerks haben, um gestörte und gefährdete Studenten rechtzeitig zu erreichen – «rechtzeitig» sozioökonomisch gesehen, d. h. früh genug, dass man noch ein anderes Fach wählen oder das Studium abbrechen kann. Rechtzeitig heisst aber auch, früh genug im Sinne der Prophylaxe gravierender sozialer Auswirkungen der Neurose und des Suizids.

Unter dem Gesichtspunkt des Erreichens des gestörten Studenten sind enge Kontakte mit den Hochschullehrern und Verwaltungsorganen unerlässlich. Hier muss einfach jener Anteil psychosozialen Wissens vermittelt werden, der ein Bemerken von Gefährdungen und verständnisvolles Weiterleiten ermöglicht. Aber auch Anregungen zur Korrektur anachronistischer Verhaltensstile und Verwaltungsschablonen sollten gegeben werden. In ebenfalls häufigeren Gesprächen mit Studenten-Vertretern wären Realität und Utopie aufeinander zu beziehen.

Schliesslich müsste auch Forschung über die spezielle Alters- und Sozialsituation von Studenten möglich sein, denn jede empirische Erweiterung des theoretischen Konzeptes bedeutet auch eine Erweiterung der psychotherapeutisch-technischen Möglichkeiten. Aus unseren bisherigen Erfahrungen möchte ich einige Kristallisationspunkte der zukünftigen Forschung nennen, als erstes die grundsätzliche Frage: Handelt es sich bei den psychischen Störungen der Spätadoleszenz in einer herausgehobenen Sozialsituation lediglich um vorübergehende Entwicklungs- und Anpassungskrisen bei sonst gesunden Ausgangspersönlichkeiten oder aber um Symptombildungen auf dem Boden einer neurotischen Charakterstruktur? Einige – vornehmlich angelsächsische Hochschulpsychiater – neigen zu der ersten Auffassung, wonach die Neurosenhäufigkeit etwa zu halbieren wäre, und verschiedene und abgekürzte Therapieverfahren auch ihre theoretische Rechtfertigung fänden. Unter den Einzelproblemen sind die bei mindestens Dreiviertel der Patienten anzutreffenden Arbeitsstörungen zu nennen, die uns vor den Fragenkreis der zwangsneurotischen Abwehr stellen. Sie fordern aber auch den Projektionsschirm der Eltern-Kind-Auseinandersetzung, die Universität, auf, klarer zu definieren, wo sie nun Zwang und wo Freiheit meint. Es ist sicher kein Zufall, dass unter den Patienten unserer Beratungsstelle die Studenten der philosophischen

Fakultät mit +9 %, der theologischen mit +6 %, der medizinischen mit +1 % gegenüber ihrem Anteil in der Gesamtstudentenschaft überrepräsentiert sind, wohingegen die juristische mit –4 % und die wirtschaftswissenschaftliche Fakultät mit –4,5 % seltener sind. Neben möglichen Vorurteilen gegenüber psychotherapeutischer Behandlung werden wir auf die Motivation der Fachwahl und die unterschiedliche Struktur der Studiengänge verwiesen.

Auch die Sexualstörungen der Universitätsangehörigen wären u. a. im Kontext ihres Hintergrundes zu betrachten. So rechtfertigt die begründet zu vermutende Häufigkeit latenter und manifester Homosexualität die Frage: Wie sieht es an der Universität mit offenen und verborgenen Konkurrenzverhältnissen und -konflikten aus? Die subjektive Klage der Patienten lautet immer wieder, dass man als Student weder seinen Leistungs- noch seinen Reifungszustand recht definieren könne, weil die Situationen so schwer überschaubar und die Konkurrenzverhältnisse so diffus seien.

Schliesslich sollte die studentische Rebellion unsere besondere Aufmerksamkeit verdienen. Sie ist sicher eine allgemeine Reaktion und hat viele Wurzeln in der realen Situation von Universität und Gesellschaft, steht aber auch, wie ich meine, dem schizoiden Pol des Erlebens am nächsten. Ein Teil ihrer Führer ist nach allem, was man weiss, moralisch-utopisch orientiert und beantwortet Machtauseinandersetzungen und -verschiebungen der Umgebungsgesellschaft mit einer Art sechsten Sinn für die Schwächen der anderen. Der Umgang mit schizoiden Menschen stellt uns vor ganz besondere Probleme der Nähe und Distanz; es ist immer wieder eingesprengtes Hinweisen auf die Realität notwendig, damit sie nicht nur sich fühlen, sondern auch ihre Umwelt sehen lernen.

Ohne den Anspruch einer systematischen Untersuchung sollten hier ein Überblick über erste Erfahrungen auf dem Gebiet des studentischen Gesundheitsdienstes gegeben und einige Schlussfolgerungen gezogen werden. Ist die Funktion eines studentischen Gesundheitsdienstes als ein Netzwerk zu sehen, in deren Zentrum die Psychiatrie stehen sollte, so ist seine Hauptaufgabe, den Leidenden rechtzeitig zu erreichen und einen Auseinandersetzungsprozess in Gang zu bringen, der den einzelnen seiner selbst bewusster macht, aber sicher nicht nur ihn allein betrifft.

Zusammenfassung

Es wird über Erhebungen bezüglich der Häufigkeit studentischer Gesundheitsstörungen berichtet und eine Beziehung zur sogenannten «schizoiden

Persönlichkeitsstruktur» festgestellt. Die Bedeutung des Selbstmordproblems für Studenten wird unterstrichen. In einem studentischen Gesundheitsdienst sollten Psychotherapeut, Psychologe und Soziologe zusammenarbeiten. Die Schwerpunkte ihrer Aufgabengebiete und deren Begründung werden erörtert. Sodann werden Möglichkeiten spezieller therapeutischer Massnahmen, insbesondere die psychotherapeutische Gruppe erläutert. Zuletzt wird der Gesichtspunkt des Erreichens des gestörten Studenten i. S. der sozialen Feldarbeit als besonders dringlich herausgestellt.

Summary

The occurrence of health disturbances in a student population is statistically evaluated and a relationship established to the so-called 'schizoid personality'. Emphasis is placed on the problem of suicide among students. In a student health service psychotherapists, psychologists and sociologists ought to work together. The main aspects and the background of the fields covered by their work are discussed. The possibilities of special therapeutic procedures, particularly of group psychotherapy, are then expounded. Finally, stress is laid on reaching the disturbed student by way of social field work.

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Problèmes particuliers de la psychothérapie individuelle d'étudiants en période d'examens

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Le but de ce travail est d'examiner les difficultés particulières que nous avons observées dans la psychothérapie individuelle d'étudiants au cours de la période d'examens et de préparation aux examens. Pour ce faire, il nous faut avant tout définir brièvement nos termes et indiquer comment se présentent les examens dans notre université.

En Belgique, les études universitaires comportent de quatre à sept années, le passage d'une année à la suivante étant subordonné à la réussite d'une session d'examens. Les examens sont en effet groupés en *sessions*, qui comportent selon les facultés et les années entre quatre et dix-sept examens oraux répartis sur une durée de deux à cinq semaines. L'étudiant qui échoue à la session de juillet peut se présenter à la session de septembre. Les cours se terminent environ un mois avant la session de juillet et le mois est utilisé à une préparation intensive des examens.

Les étudiants dont nous serons amenés à parler sont ceux qui sont traités au Service d'Aide Psychologique aux Etudiants de l'Université Libre de Bruxelles. Pour certains d'entre eux, la difficulté à étudier, à assimiler et à passer des examens constitue un aspect dominant de la plainte principale ou de la psychopathologie. Mais pour d'autres, les difficultés principales se situent en dehors du domaine des études.

Lorsque nous parlons de psychothérapie, nous entendons une psychothérapie individuelle, d'inspiration psychanalytique, que nous pouvons caractériser en disant qu'elle est «à objectifs limités» ou «en secteur» ou plus simplement avec Malan [1963] «brève».

L'étudiant devant l'examen

Pour la quasi-totalité des étudiants, la période de préparation à la session d'examens et la session elle-même entraînent une fatigue physique importante et une tension psychologique croissante qui devient parfois extrême.

L'examen peut être vécu très diversement. Bien des étudiants, psychologiquement très immatures, réussissent leurs examens en les passant comme des écoliers studieux. Mais dans d'autres cas, l'examen est avant tout investi d'affects narcissiques et constitue à ce titre un terrain de choix pour l'expression des mécanismes de défense. Nous pensons par exemple à cet étudiant extrêmement masochique pour qui l'échec aux examens qu'il venait de présenter ne faisait aucun doute. Aussi, son désarroi fut-il considérable lorsqu'il apprit qu'il était reçu. Cette réussite était véritablement un acte manqué. «J'étais, déclarait-il, psychologiquement préparé à l'échec», et son anxiété était grande devant la situation valorisante qu'il devait assumer.

L'examen peut aussi être vécu comme une épreuve menant à la maturité adulte. Les échecs tardifs au cours des études sont souvent la marque de ce que l'accès à cette maturité adulte est interdit. C'est dans ces cas que l'on voit le plus clairement à quel point les examens tendent à réactiver les conflicts non résolus avec la figure paternelle.

Enfin, notons que la perspective des examens entraîne volontiers une régression vers des attitudes plus dépendantes. Les mères à tendances surprotectrices s'entendent bien à exploiter cette régression!

La situation du psychothérapeute d'étudiant

Traiter l'étudiant qui présente des troubles émotionnels, c'est à notre sens essentiellement l'aider à mûrir, à devenir adulte. C'est aussi, bien entendu, faire en sorte que diminue sa psychopathologie. Enfin, c'est le plus habituellement lui permettre de progresser normalement dans sa carrière d'étudiant, c'est-à-dire, de réussir des examens. L'objectif thérapeutique dans un service destiné aux étudiants doit en effet, le plus souvent, inclure la réussite aux examens. Parfois, il peut comporter une réorientation et le départ de l'Université. Mais l'objectif thérapeutique ne saurait s'accomoder de l'échec aux examens et moins encore de l'échec répété. De même, la réussite professionnelle fait partie des objectifs classiques de toute psychothérapie. Mais cette réussite est habituellement un objectif à

plus ou moins long terme, et non, comme c'est le cas pour nos étudiants, une sorte de réussite annuelle, obligées, dans un temps limité. La nécessité de cette réussite à date fixe peut entrer en conflit avec les objectifs plus généraux d'une psychothérapie. On doit même poser ici le problème de la préservation de traits névrotiques, obsessionnels par exemple, favorables à l'étude assidue et à la réussite des examens.

De toutes manières, le problème des examens interfère dans le cours normal d'une psychothérapie, surtout dans un service destiné aux étudiants: ce problème se pose en même temps à tous les étudiants en traitement . . . et à tous les thérapeutes.

L'étudiant en cours de psychothérapie devant la session d'examens

Dans la plupart des cas, la tendance à la régression apparaîtra dans la psychothérapie, et l'étudiant aura souvent des réactions de dépendance accrue à l'égard du thérapeute. Normalement, ces réactions de dépendance apparaîtront dans le transfert, ouvertement ou de manière dissimulée: sur le plan verbal sous forme de fantasmes, ou sur le plan de ce que l'on a appelé l'«acting in», c'est-à-dire sous forme motrice, tonique ou neurovégétative. Mais parfois aussi les réactions de l'étudiant seront plus directement agies: dans la mesure où le traitement est vécu comme un soutien sécurisant et favorisant la dépendance, on peut voir l'étudiant tenter d'obtenir du thérapeute diverses sortes de gratifications. Tel étudiant, à caractère captatif oral, réclamait des médicaments pendant la préparation des examens. Plus tard, ses revendications ne portèrent plus que sur les marques d'intérêt et d'affection, par des remarques comme: «Vous, cela vous est égal! Vous faites votre métier en m'écoutant parler . . . Vous ne pourriez pas être un peu plus humain?!» Il s'agissait, on le voit, de forcer le thérapeute hors de sa position de neutralité, et finalement de lui faire partager de quelque manière la responsabilité du résultat académique. Chez ce sujet, le retour à la pensée magique était étroitement lié au besoin de dépendance, et notamment, il ne pouvait se défendre de l'idée que son thérapeute était susceptible d'intervenir en sa faveur auprès des professeurs. La demande de séances plus fréquentes, qui est l'expression la plus évidente du besoin de soutien sécurisant, n'est cependant pas la plus habituelle, car elle est peu compatible avec l'élément objectif du temps limité dont dispose l'étudiant.

Inversement, quand les séances sont relativement anxiogènes et ne satisfont pas le besoin de dépendance de l'étudiant, on pourra voir apparaître des demandes d'espacement des séances ou de suspension du traitement. L'étudiant justifie de telles demandes par «la peur de perdre du temps pour l'étude», la peur d'être distrait de son travail par les problèmes soulevés au cours des séances, autrement dit la peur d'être rendu anxieux par les conflits actualisés au cours du traitement. Mais le plus souvent, ces demandes sont surdéterminées. La proximité de l'examen est perçue comme une situation exceptionnelle, utilisable dans le jeu du transfert.

Un exemple illustrera mieux cette surdétermination: un étudiant, par ailleurs très dépendant, expliquait avec beaucoup de raison qu'une heure de psychothérapie lui coûtait au moins une demi-journée de travail, puisqu'il s'y préparait émotionnellement plusieurs heures avant la séance et en était encore impressionné longtemps après. L'argument paraissait de poids. Mais en y regardant de plus près, il apparut qu'en réalité le plaisir qu'il prenait à ces séances le culpabilisait considérablement. Ceci tiré au clair, l'argument rationnel sembla perdre de sa valeur puisque le sujet continua de venir jusqu'à la veille de la session.

Il importe, croyons-nous, de discerner clairement les motivations profondes de la fuite – puisque de toute façon c'en est une – et d'apprécier pour chaque cas les éléments qu'il est souhaitable d'élucider pour réduire l'anxiété au minimum. Il est possible que ces réactions d'acting-out soient liées à la forme du traitement; qu'elles soient d'autant moins fréquentes que la structure et le climat du traitement sont plus proches de ceux d'une cure-type psychanalytique. Mais il se peut aussi que la personnalité et la technique propre au psychothérapeute jouent ici un rôle important.

La réussite de l'examen peut être «dynamogène», faire faire à l'étudiant un pas en avant dans le sens de la maturité; mais elle peut aussi entraîner des réactions de gratitude excessive à l'égard du thérapeute, et une forme nouvelle de dépendance envers lui. L'échec, lui, peut entraîner des réactions, soit de culpabilité, soit d'agressivité envers le thérapeute. Un étudiant qui avait consulté pour échecs répétés peu avant la session de juillet et qui échoua de nouveau aux deux sessions ne reparut chez son thérapeute qu'au mois de novembre, ayant pris une nouvelle orientation qu'il jugeait de moindre valeur.

Le psychothérapeute devant la session d'examens

Qu'il le veuille ou non, le thérapeute d'étudiants subit lui aussi la pression de la session d'examens. Pour accomplir son travail de thérapeute, il doit en effet nécessairement, pour une partie de lui-même, s'identifier à l'étudiant. Tout le problème est précisément de conserver cette capacité d'identification partielle tout en conservant le contrôle de ses réactions contre-transférentielles. Les réactions de dépendance accrue de l'étudiant vont stimuler les tendances surprotectrices du thérapeute, situation banale au cours de toute psychothérapie, surtout lorsque le patient est un adolescent. Mais le problème se complique dans la mesure où le thérapeute investit narcissiquement la réussite de son patient à l'examen. Or, ce risque est accru lorsque le thérapeute, travaillant dans un service intégré à l'Université, s'identifie plus ou moins consciemment à celle-ci et à ses objectifs.

De toute manière, reconnaissons que l'échec de l'étudiant aux examens est vécu dans la plupart des cas par le thérapeute sinon comme un échec pour lui-même, du moins comme une blessure narcissique.

Conséquences pratiques

Tous les phénomènes indiqués ci-dessus entraînent le thérapeute à tenir compte de ce facteur de réalité qu'est la session d'examens, et des réactions qu'elle suscite chez l'étudiant et chez lui-même. Nous pouvons poser en principe que là où c'est possible sans nuire à l'avenir de la psychothérapie, le thérapeute cherche à favoriser la réussite de l'examen ou du moins à ne pas l'entraver. Ceci peut le conduire à diverses modifications d'attitude ou de technique.

Fréquemment, le thérapeute va éviter des interventions ou des interprétations de nature à susciter de l'angoisse, ou à rendre plus aigus les conflits psychologiques du patient. Il va ainsi passer sous silence des interprétations possibles et utiles à la psychothérapie dans son ensemble, et devra attendre ensuite, parfois longtemps, que se représente le moment favorable pour les formuler.

Une situation typique à cet égard est celle où l'étudiant, jusque là inhibé, entame une relation avec une femme à l'approche de la session d'examens. Cette relation sera évidemment difficile à soutenir sans entrer en conflit avec l'étude. Sans doute plusieurs interprétations viennent aussitôt

à l'esprit: la relation n'a-t-elle pas pu prendre naissance précisément parce que l'approche des examens offrait un moyen commode de la fuir? Ou bien, au contraire, la relation entamée constitue-t-elle une fuite du problème des examens, une justification de l'échec à venir, sous une forme capable de gagner les bonnes grâces du thérapeute? On peut se demander aussi quelle est la signification, sur le plan du transfert, de cette relation débutante? Ne tend-elle pas soit à satisfaire le thérapeute, soit à mettre celui-ci à l'épreuve sur la base du dilemne: examens ou vie sentimentale? Sans nul doute, l'attitude la plus correcte en principe consiste à donner l'interprétation adéquate. Mais il n'est pas toujours facile pour le thérapeute de dire, même si c'est exact, que le patient met en avant le problème de ses examens pour fuir la relation avec son amie. Si en effet l'étudiant échoue finalement, la position du thérapeute peut devenir délicate.

L'interprétation de l'angoisse devant les examens n'est pas aisée, et le fait que le thérapeute se sente tenu par un délai, celui qui le sépare de la date de la session, peut compliquer singulièrement sa tâche. Un exemple récent illustre assez bien la nécessité du dosage des interprétations en fonction de la proximité des examens:

> Un étudiant, de caractère très masochique comme il apparaîtra plus loin, arriva à la séance, ayant cristallisé sur un seul cours toute son angoisse des examens, et redoutant l'échec comme une catastrophe. Il paraissait urgent au thérapeute d'élucider pourquoi ce cours-là était la pierre d'achoppement, bien que le sujet craignît très consciemment d'aborder ce problème. Mais une fois la situation mise en lumière, il se détendit, attestant l'utilité de l'opération. Pourtant, la détente s'exprima d'une manière paradoxale: il acceptait maintenant l'échec à la session de juillet et voyait même toutes sortes d'avantages à se présenter à nouveau aux examens de septembre! Cette volte-face peu encourageante à première vue, indiquait au contraire chez ce masochiste que la partie était gagnée: en effet, il allait pouvoir réussir en juillet puisqu'il avait trouvé un moyen de payer sa réussite (à savoir: se priver de tous les avantages en question). Le mécanisme était clair, mais quel est le thérapeute qui voudrait y toucher . . . avant la fin des examens?

Dans d'autres cas encore, le thérapeute sera amené à prendre des attitudes de soutien ou plus ou moins directives là où auparavant il avait conservé une neutralité bienveillante. Il est difficile, en pareil cas, de revenir à une position de neutralité sans s'être expliqué sur ce qui s'est passé.

Quant aux cas où l'étudiant demande un changement du rythme des séances, ou une suspension du traitement, nous avons vu qu'ils exigent un examen soigneux avant de décider comment cette demande va être inter-

prétée et si elle va être acceptée ou refusée. En particulier, l'acceptation d'une réduction des séances ou de la suspension du traitement peut être vécue par l'étudiant soit comme une participation du thérapeute à son angoisse devant les examens, et donc accroître cette angoisse, soit au contraire, elle peut être perçue comme une reconnaissance par le thérapeute de la maturité croissante de l'étudiant, rendant moins nécessaire la dépendance liée au traitement. Par là, l'étudiant peut se sentir plus confiant et en quelque sorte fortifié.

Nous avons cité ce que nous pensons être les principales éventualités. Bien d'autres peuvent survenir, qui mettent chaque fois en cause les réactions contre-transférentielles du thérapeute à l'égard du patient, teintées parfois par la position personnelle du thérapeute à l'égard de l'Université et des examens eux-mêmes.

Résumé

La session d'examens constitue une difficulté propre à la psychothérapie d'étudiants. Elle impose fréquemment de mettre en balance les objectifs à long terme de la psychothérapie et les buts à court terme. Elle nécessite pour le thérapeute une vigilance particulière à l'égard de ses réactions contre-transférentielles.

Summary

Examination time presents a problem inherent to the psychotherapy of students, often making it necessary to weigh up the long-term and short-term aims of psychotherapy. Particular alertness is demanded of the therapist with regard to his reactions of counter-transference.

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Student und Neurose

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Die *psychischen Störungen bei Studierenden* stellen ein auffälliges psychosozial-medizinisches Phänomen dar. Doch bleibt dabei noch offen, ob ihre Häufigkeitszunahme lediglich in Relation zu den beträchtlich erhöhten Studentenzahlen steht oder tatsächlich absolut ist. Die psychischen Auffälligkeiten der Studierenden sind keine Novität der letzten Jahre. Dies zeigen bereits Untersuchungen aus den dreissiger Jahren; wir selbst beschäftigen uns damit seit 1953.

Die *Häufigkeits*angaben von psychischen Störungen bei Studierenden liegen zwischen 2 % und 90 %; man kann mit einer solchen um/bis 20 % rechnen. Die Schwierigkeiten, verlässliche Zahlen dieser Art zu gewinnen, hängen vor allem auch von den jeweils angewandten *diagnostischen Kriterien* ab. Dies zeigt sich vor allem darin, dass verschiedenartige, sich nicht deckende Bezugsschemata, Aspekte und Interpretationen zur Klärung und Erfasung des Phänomens der psychischen Störungen bemüht werden. Sie sind in der folgenden Übersicht zusammengestellt:

Interpretationen

akademische	Faulheit, Dummheit
legendäre	wirtschaftliche Schwierigkeiten Überarbeitung Überforderung
soziologische	Anpassungsprozess an die Universität Sozialer Status der Eltern

psychologische	Selbstunsicherheit Trennung vom Familienmilieu
theologische	Verlust der Mitte, des Personenwertes
politische	Repressive Struktur der Hochschule
medizinische	vegetative Dystonie, Psychose

Sicher ist, dass der *Arzt* im allgemeinen auch diesen Phänomenen weitgehend *hilflos* gegenübersteht. Dies liegt vor allem an der unzureichenden Information über psychodynamische Zusammenhänge; Kenntniserwerb, Ausbildung und Erforschung dieser Geschehnisse sind auch heute noch nicht immer frei von Behinderung und Einschränkung.

So werden – beispielsweise – die Konzentrationsstörungen eines Studenten vom Arzt auf dessen Gastritis zurückgeführt; diese bewirke Stoffwechselstörungen, die sich im Gehirn äussern.

Oder: Die Herz- und Angstsymptomatik, die einen Studenten bei der Arbeit befällt und ihn studienunfähig macht, bleibt in ihrem Wesen und ihrer Bedeutung auch in einer Fachklinik unverstanden.

Wenn wir hier einiges zum Thema «Student und Neurose» mitteilen, so stützen wir uns dabei auf eine langjährige Beschäftigung auf diesem Gebiet. Unsere Erfahrungen beruhen

a) auf ambulanten Untersuchungen psychisch auffälliger Studenten in unserer *Studentenberatung* (Psychotherapeutische Abteilung der Nervenklinik der Freien Universität [FU]). Ihre Anzahl beläuft sich zurzeit auf 200 Patienten pro Jahr. Unsere diagnostischen – *psychiatrischen und psychoanalytischen* – Kriterien werden ergänzt durch die des klinischen Psychologen; in einer besonderen Studie sind sie durch die des *Soziologen* erweitert;

b) ferner auf mehreren Hundert (*nerven-*)*klinisch* untersuchten und behandelten Studierenden;

c) auf eigenen psychoanalytischen Behandlungen. Sie beziehen auch Informationsmaterial von Mitgliedern des Berliner Psychoanalytischen Instituts bzw. der Deutschen Psychoanalytischen Vereinigung mit ein. Dabei wird ein Patientengut von über 100 Studenten mit 50 bis 2000 Behandlungsstunden übersehen.

Als Ergebnisse einiger «harter» Daten seien erwähnt:

1. Die Anzahl der neurotischen Studenten aus *inkompletten Familien* ist nicht kennzeichnend höher als die, die aus der Gesamtzahl der Studenten Westdeutschlands und West-Berlins (1963) ermittelt wurde (40,2 % gegenüber 36,5 %).

2. Die *soziale Stellung* des Vaters differiert ebenfalls nicht von der statistischen Vergleichszahl.

Akademiker	35,0 %	33,7 %
Arbeiter	6,0 %	5,9 %

3. Im *Elternhaus wohnen* ca. 25 % unserer Untersuchten; dies ist etwas weniger als die Anzahl der Vergleichsgruppe der FU-Studenten (1963; 39 %).

4. *Fakultätszugehörigkeit:* Bei den neurotischen Studierenden sind die Studenten der *philosophischen* Fakultät eindeutig überrepräsentiert.

Hier beziehen wir uns vor allem auf die mit ca. 90 % am häufigsten vorliegende Symptomatik, die *Lern-, Arbeits- und Leistungsstörungen.* Sie stellen sich sehr oft in einem umfassenderen Syndrom dar.

Bevor ihre *Symptomatik skizziert,* ihre *soziale Relevanz erörtert* und die *Phänomene interpretiert* werden, soll zu dem Eindruck und der vorschnellen tendenziösen Interpretation der Arbeitsstörungen als Effekt der Universität folgendes bemerkt werden:

1. Gleiche oder ähnliche Störungen liegen auch bei nicht studentischen Patienten vor;

2. der gleiche Patient hat sehr oft bereits *vor* wie auch dann *nach* seinem studentischen Sozialstatus manifeste neurotische Störungen;

3. die (neurotische) Symptomatik äussert sich stets *auch* in *anderer* Weise als im intellektuellen Leistungsbereich; sie ist also keineswegs nur studienbezogen, oft studienunabhängig.

4. Präzise Untersuchungen und Ergebnisse, die über Mutmassungen hinaus ein soziodynamisches Konzept der Störungen gewinnen lassen, liegen nicht vor.

Im Gegensatz zu den mehr tendenziösen Behauptungen bringt erstaunlicherweise der betroffene Patient selber seine Störungen und Symptome praktisch nie in ursächlichen Zusammenhang mit dem Universitätssystem. Das impliziert keineswegs notwendige Optimalisierungen mancher entwürdigenden universitären Gegebenheiten; sie sind jedoch (noch) nicht als neurotogene Faktoren zu identifizieren. Es muss daran erinnert wer-

den, dass Störungen bei Studierenden in verschiedenen Städten des In- und Auslandes mit unterschiedlicher Universitätsstruktur und sogar nach Durchführung von Reformen vorliegen. Selbst wenn sich einmal klare Sachverhalte soziodynamischer Art präzisieren lassen sollten, würden diese nur eine überformende Bedeutung der wesentlicheren individuellen Konflikte haben.

5. Die psychoanalytischen Erfahrungen mit Patienten, die sowohl neurotisch als auch Studierende sind, zeigen deren intrapsychische Konfliktkonstellationen. Dass dabei im Rahmen der Entwicklungsproblematik solche (Trieb-)Konflikte von wesentlicher Bedeutung sind, wird durch das *obligate Vorliegen sexueller Störungen* belegt.

Befunde und Diskussion

A. Die Arbeitsstörungen zeigen oft neurosenstrukturelle Ausprägung, z. B. *zwangsneurotische* Lernstörung; durch Kopfschmerz und andere Konversionssymptome bedingte *hysterische* Beeinträchtigungen oder *angsthaft*-phobische Reaktionen etc. Häufig ist das Bild der (depressiven) *Erschöpfungsneurose* mit charakteristischen Symptomen wie Apathie, Ich-Einschränkung, hochgradige Insuffizienz u. a. m.

Bei den *Lern- und Arbeitsstörungen* lassen sich solche unterscheiden, die I. *bereits in der Schulzeit* deutlich wurden. Es bestand ständiges Desinteresse am Lernen. Ohne besondere Bemühungen war man gewohnt, der Realität auszuweichen. So finden sich Sitzenbleiben in der Schule, Nichtbestehen des Abiturs etc., wobei mehr hysterische und Verwahrlosungsstrukturen, mehr passiv-resistente Züge vorzuliegen scheinen.

Demgegenüber treten II. in anderen Fällen die Arbeitsstörungen *erstmalig während des Studiums* auf; sie kontrastieren mit sehr guten Schul- und Studienleistungen. Der Patient war bisher Klassenbester, übersprang Schulklassen, wurde vom mündlichen Abitur befreit etc. Hier liegen mehr Abhängigkeitszüge und die Verwendung der Intellektualität als Abwehr vor.

Nun wird – in beiden Fällen – auf Anforderungen, in Situationen, die durch Druck und Zwang bestimmt sind, mit Mutlosigkeit und Leistungsunfähigkeit reagiert; dabei werden aber voller *Ehrgeiz* Überleistungen und glanzvolle Erfolge erwartet. Intensive Bemühungen und erheblicher Aufwand kontrastieren mit dem mangelnden Effekt und verdeutlichen die «konflikthafte Widersprochenheit». Diese Leistungsbeeinträchtigungen

äussern sich – objektiv – als *Studienwechsel, Examensversagen, Studienabbruch und Studienverlängerung* und bedingen oft sichtlich die hohe Versagerquote mit.

So ist zur *Studienzeitverlängerung* anzumerken, dass unter unseren (58) unausgewählten psychisch auffälligen *Studierenden mit 15* und mehr Semestern der Anteil der Psychosen 12 % beträgt; er ist damit (etwa) *dreimal* so hoch wie bei unserem Gesamtuntersuchungsgut.

Die *hohe Versagerquote* wird gerne mit der sozialen Situation des Studenten in Verbindung gebracht, nämlich auf die Unsicherheit seines Status, auf niedrige akademische Anforderungen, aber auch auf ausserordentlich starken Leistungsdruck. Darin auch gemeinsame Gründe für die *politischen Unruhen* in verschiedenen Ländern zu sehen, erscheint uns mehr als eine offene Frage, zumal psychopathologische Merkmale und individuelle Konfliktbereiche bisher noch ausser acht blieben.

Unmerklich gehen diese *Arbeitsstörungen* in die Symptomatik der (neurotischen) *Prüfungsangst* über. Dabei kontrastieren erfolgreiche, gute und sehr gute Teilprüfungen mit der Heftigkeit quälender Ängste. Damit stellt sich das Problem des *Krankheitswertes der neurotischen Prüfungsangst.* Es taucht oft genug auf, z. B. dann, wenn ein Kandidat vor seiner Prüfung aus Angst zurücktritt oder wenn es zu Leistungsversagen in einer Prüfung kommt. Dies gilt auch für die (zuweilen rückwirkende) Beurlaubung eines oder mehrerer Studiensemester wegen der Lern- und Arbeitsunfähigkeit.

Dass auch hierbei die *Rechtsprechung* unrealistisch ist, belegt ein in diesem Zusammenhang oft zitiertes Urteil des Bundesverwaltungsgerichts. Danach unterliege es keinem Zweifel, dass eine «Examenspsychose» keinen besonderen Härtefall darstellt, eine (zweite) Examenswiederholung zu rechtfertigen. Hierzu ein Beispiel, das auch vor *vorschnellen ätiologischen Festlegungen* warnen soll:

Ein Student, der am Ende seines Studiums sein Abschlussexamen machen wollte, wurde in einem anderen Land für ½ Jahr *inhaftiert.* Danach war er nicht mehr in der Lage, das geplante Examen abzulegen. Nach mehreren Jahren anderweitiger Berufstätigkeit versuchte dieser Student nun erneut, sein Abschlussexamen zu machen. Obwohl er nur 1–2 Semester nachholen wollte, führte er noch einmal das *gleiche gesamte Studium durch.* Wiederum war er – diesmal ohne Inhaftierung – unfähig, das Examen abzuleisten.

Bei dem Trend, lediglich die *traumatische* Wirkung von Ereignissen als ursächlich gelten zu lassen, ignoriert man das damit verknüpfte *relevantere Konfliktgeschehen.* Da diese eigentümliche Erkenntnisweise bevorzugt bei gutachtlichen Äusserungen gilt, sollte man sie als «Gutachten-Psychopathologie» oder «Gutachten-Psychiatrie» absondern.

B. Von den vielen anderen (nicht-intellektuellen) Störungen und Verhaltensbeeinträchtigungen sind noch *Hypermotorik* und *Hyperorexie* zu er-

wähnen. Anstelle der geforderten und intendierten intellektuellen Tätigkeit kommt es zu zwanghaftem Essen-Müssen oder motorischer Entladung als stundenlanges Marschieren oder ständiges unruhiges Hin- und Herlaufen.

Dass die Beeinträchtigungen nicht nur die intellektuellen Funktionen betreffen, exemplifiziert ein Student, der sich als «vollkommener Versager» fühlte, oder ein anderer, der bei sich nicht nur die richtige Beziehung zur geistigen Tätigkeit, sondern überhaupt zu sich selbst, zur Umwelt, insbesondere auch zu Mädchen vermisste.

So hatte ein Patientin *bereits in der Schule*, um ihr 14. Lebensjahr, Leistungsstörungen. Sie motivierte sie damit, dass sie aus Trotz und Wut gegen die sie vernachlässigenden Angehörigen einfach nicht mehr gelernt habe. Nach 10 Semestern ihres Studiums gab sie auf, nachdem sie im *Vorexamen versagt* und dabei ständig in den einzelnen Prüfungen Angst hatte und sich nicht konzentrieren konnte. Sie *versagte* in ihrer anschliessenden Tätigkeit als *Schwesternschülerin*, wurde dabei auch von einem exazerbierenden Ekzem behindert; sie vermied dann in einer Berufsberatung die noch anstehende psychologische Testsituation. Bevor sie ein neues Studium begann, führte sie ein *Praktikum* durch, in dem sie aber auch mit ihrer Aufgabe und den Personen ihrer Umwelt nicht klarkam, so dass sie einen *Suizidversuch* unternahm. Auch in ihren erotischen Beziehungen war sie völlig gestört.

Hier ist anzumerken, dass zuweilen *erhöhte Suizid- und Suizidversuchsziffern* bei Studenten mitgeteilt werden. Aus unserem eigenen Krankengut können wir – nach *vorläufigem* Überblick – diese Erfahrung *nicht* teilen: die Suizidziffer unserer klinischen *nicht*-studentischen neurotischen Patienten (11 %) differiert nicht von der der neurotischen Studenten.

C. *Verhaltensstörungen* treten als Ich-Einschränkung, Interessen- und Kontaktverlust, Erschöpftsein sowie Primitivierung hervor. Es sind ständig wiederkehrende, oftmals fulminante klinische Bilder. Bei ihnen imponiert die Wirksamkeit latenten oder manifesten *Schuldgefühls*. Unter seinem Druck zwingt man sich zu ständiger Arbeit, erlebt aber auch, dass Lernen, sich Wissen aneignen, *verboten und gefährlich* sind. Die unbewussten Auseinandersetzungen mit dem väterlichen Objekt misst sich an der Heftigkeit, der *Angst* zu konkurrieren, *bestraft* zu werden oder *Erfolg* zu haben. Aber es ist auch der «Wille zum Fehlschlag», die «Lust sich selbst zu blockieren», wie diese *aggressiven* Valenzen formuliert werden. Die (unbewussten oder bewussten) *Rachetendenzen* gehen mit dem (unbewussten) *Wunsch zu versagen* einher.

Eine Studentin im *15. Semester* hatte noch *kein Vorexamen* abgelegt. Ihre Störungen waren vor allem durch Auseinandersetzungen mit ihrer Mutter bestimmt. Diese erlebte sie ständig mit geschwungener Peitsche hinter sich, zum Lernen und Studieren antreibend. Die gegen sich selbst gerichtete Aggressivität äusserte sich nun in einem *Selbstmordversuch.*

Im Verhalten und Erleben der Studenten imponiert oft sehr eindrucksvoll die *Perpetuierung der kindlichen Rollenfunktion,* wobei die infantile Unselbständigkeit durch Unfähigkeit und Misserfolg gewährleistet wird. Sie macht damit die immanenten *Entwicklungskonflikte* «zwischen dem Bestreben zu verharren und der Veränderung durch neue Realforderungen» deutlich. Zu dieser Abhängigkeits-Unabhängigkeitsthematik kommt die von Aktivität und Passivität, was sich als *Identifizierungskonflikt* ausdrückt.

So verficht ein 10semestriger Student mit neurotischen Beschwerden sein Ideal des ewigen Oberprimaners.

Ein 26jähriger Patient, der mit einem Suizidversuch auffällig wurde, lehnte schon seit seinem 15. Lebensjahr ab, erwachsen zu werden. über Jahre hindurch applizierte er weibliches Keimdrüsenhormon; bewusst als therapeutische Massnahme gegen seinen Haarausfall, jedoch entscheidender determiniert wegen der damit erstrebten Desexualisierung.

Ein anderer Student verharrte in der *Abhängigkeit* der überwachenden Kontrolle seines Vaters, der er sich nicht zu entziehen vermochte. Dieser kam aus der Ferne herangereist und wohnte semesterlang – gleichsam als Aufseher – mit im Zimmer des Patienten.

Ein Student beklagte sich u. a. über die beengenden Verhältnisse zu Hause. Obwohl er an eine auswärtige Universität geschickt worden war und dort ein eigenes Zimmer hatte, war er jedoch nicht in der Lage, ohne die neurotische Verklammerung seiner Mutter zu leben und zu studieren. Er kehrte wieder von sich aus in das beengende Elternhaus zurück.

D. Die besondere Rolle und Bedeutung der *sexuellen Triebimpulse* lässt sich in folgenden Sätzen zusammenfassen:

1. *Die intellektuellen Leistungsstörungen gehen immer mit sexuellen Beeinträchtigungen einher.* Diese äussern sich in den vielfältigen Formen der Impotenz, also in Hemmung, auch in angsthaftem Vermeiden und Rationalisieren, in verstärktem Narzissmus mit Bindungsunfähigkeit sowie latenter Homosexualität.

So werden Hass und Ekel vor Mädchen empfunden, der Koitus als Gewaltakt abgelehnt oder jegliche Intimsbeziehungen vermieden etc.

Dieses unreife Sexualverhalten ist aggressionsbesetzt. In gleicher Weise

bezieht sich die Angst auf Lernaktivitäten und Prüfungen (Autoritäten) wie auch auf das andere Geschlecht. Die Persistenz oder regressive Reaktivierung der heftigen ödipalen Konflikte sind evident.

2. Intellektuelle und sexuelle Fähigkeiten schliessen sich aus.

So befürchtete ein Student, dass die Lerntätigkeit durch sexuelle Aktionen lahmgelegt wird.

Ein anderer ist nach vereinzelten intimen Beziehungen jeweils völlig geschwächt und wochenlang unfähig zu arbeiten.

Ein anderer deklariert die Unvereinbarkeit von Studium und sexuellen Beziehungen.

Bei einem weiteren Studenten wurde die exzessive Lernstörung manifest, nachdem er in die Wohnung seiner Freundin gezogen war.

3. Die gehemmte unreife Form der (sexuellen) Triebenergie, die die intellektuelle Ich-Tätigkeit besetzt, geht auch mit einer Störung ihrer Sublimierung einher.

Obwohl von Partnerbeziehungen bewusst distanziert wird, diese also vermieden werden, um ungestört arbeiten und studieren zu können, bleibt die Leistungsfähigkeit doch beeinträchtigt.

So gelingt es nur eine Zeitlang, den «grossen Arbeitswillen» zu mobilisieren, als «Flucht vor dem Mädchenproblem»: Leistungsversagen wie auch Impotenz resultieren. Ebenso misslingt es dann doch, den «Hass gegen Frauen» durch das Studium zu betäuben.

Dies führt zur Annahme, dass die intellektuelle Ich-Funktion als Ersatz für aggressive, insbesondere sexuelle Triebbetätigung der Abwehr unterworfen wird. *Die an sich harmlosen Ichleistungen sind in Beziehung zu alten abgewehrten Trieb- (Sexual-) Handlungen geraten; sie haben deren Vertretung übernommen und ziehen als triebbesetzte (sexualisierte) Tätigkeiten die Abwehr* auf sich [A. FREUD].

Zusammenfassung

Die neurotischen Auffälligkeiten von Studierenden imponieren als ein Syndrom, bei dem in erster Linie Lern- und Arbeitsstörungen, auch Angst vor Leistungsbeweis bzw. Erfolg, stets aber nicht intellektuelle Beeinträchtigungen (z. B. Hyperorexie und hypermotorische Entladungen) und Verhaltensstörungen (Ich-Einschränkung, Interessen- und Kontaktverlust, Erschöpftsein und Primitivierung) vorliegen.

Insbesondere demonstrieren die – verschiedenartigen – obligaten Beeinträchtigungen der sexuellen Fähigkeit, dass mangelnde Sublimierung bzw. Neutralisierung sexueller und auch aggressiver Triebenergien im Rahmen von Entwicklungs- (und Identifizierungs-) Konflikten von wesentlicher Bedeutung sind.

Summary

The neurotic behaviour of students gives the impression of being a syndrome of, in the first instance, disturbances in learning and working and also of anxiety about achievement and/or success but always of non-intellectual impairments (e. g. hyperorexia, hypermotor discharges) and of behaviour disturbances (ego-restriction, loss of interests and contact, exhaustion, primitive reactions).

In particular the various inavoidable impairments in the sexual function clearly demonstrate the considerable importance of the failure to sublimate and/or neutralize sexual and aggressive driving forces within the bounds of the conflicts arising during development (and identification).

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